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Gurisha Taranjeet Kaur (an infant suing by her father and litigation representative, Taranjeet Singh s/o Bhagwan Singh) & Anor v Dr Premitha Damodaran & Anor

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HIGH COURT (KUALA LUMPUR) — SUIT NO 22NCVC-655–12 OF 2015
FAIZAH JAMALUDIN J
20 MAY 2020

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Tort — Professional negligence — Medical practitioner — Claim against — Whether first defendant owed her patient duty to advise her on her delivery options — Whether first defendant provided second plaintiff with any information about her risk factors — Whether first defendant undertaken incorrect management of shoulder dystocia complication — Whether first defendant applied excessive traction to free first plaintiff baby's shoulder during delivery — Whether plaintiffs proven on balance of probabilities that brachial plexus injury to baby's shoulder caused by first defendant's mismanagement of shoulder dystocia — Whether second plaintiff's perineal and vaginal injuries had been sufficiently identified, treated and managed — Contributory negligence — Whether first defendant had proven first limb of test for contributory negligence — Whether second plaintiff ought to have reasonably foreseen harm to herself and to her baby if she gave first defendant inaccurate birthweight of her first born — Whether second plaintiff was contributorily negligent for damages caused to her and her baby by first defendant's negligence — Vicarious liability — Whether second defendant vicariously liable for action of first defendant — Whether first defendant at all material times an independent contractor and not employee of second defendant — Whether second defendant had positive duty to protect plaintiffs from injury during labour and delivery — Whether second defendant was in breach of non-delegable duty of care — Quantum — Damages — Assessment of damages — Whether supported by conclusive evidence — Entitlement to special damages and general damages

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Baljeet Kaur Grewal d/o Jaswant Singh ('the second plaintiff') gave birth to Gurisha Tarajeet Kaur ('the first plaintiff') at Pantai Hospital Kuala Lumpur, which was owned and managed at the material time by Pantai Medical Centre Sdn Bhd ('the second defendant'). The first plaintiff was conceived by in-vitro fertilisation ('IVF'). During the first three months of her pregnancy, the second plaintiff had been under the professional care of Dr Prashant of the KL Fertility Centre, who had then referred her to Dr Premitha Damodaran ('the first defendant'). The first defendant was the consultant obstetrician and gynaecologist responsible for the second plaintiff's care during her pregnancy and labour and who had delivered the first plaintiff. As a result of complications

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during delivery, the first plaintiff suffered brachial plexus injury to her left shoulder. After her birth, she was diagnosed as having Erb's palsy. The second plaintiff suffered a second-degree tear to her perineum, which was later repaired by way of an operation. The plaintiffs attributed the injuries they had suffered to the first defendant's negligence. The plaintiffs thus filed a medical negligence claim against the defendants. The plaintiffs claimed that both the first and second defendant owed an independent duty of care to each of the plaintiffs. The plaintiffs' case against the first defendant was based on two distinct grounds of negligence that related to the second plaintiff's ante-natal care and the management of the second plaintiff's labour and the delivery of the first plaintiff. It was the plaintiffs' case that the first defendant owed the second plaintiff a duty to advise her on her delivery options and that she should have suspected the possibility of a shoulder dystocia complication and her inability to manage such a complication. The plaintiffs also argued that the first defendant had undertaken incorrect management of the shoulder dystocia complication. The plaintiffs pleaded that the first defendant had applied excessive traction to free the first plaintiff baby's shoulder during her delivery which caused the brachial plexus injury. The second plaintiff further contended that her perineal and vaginal injuries had not been sufficiently identified, treated and managed. The plaintiffs claimed that the second defendant was vicariously liable for any negligence of the defendant and its nurses and agents and that the second defendant owed the plaintiffs a non-delegable duty of care. In her notice of contribution and indemnity the first defendant raised that she had relied on the expertise and skill of the second defendant's nurses and midwives, who had supplied her a wrong set of forceps. She also relied on the fact that post-delivery the plaintiffs were under the care of the second defendant's staff members and that she was not liable for the second defendant's negligence of and the negligence of its servants and agents. In its defence, the second defendant submitted that it should not be held liable as the first defendant is an independent contractor and not an employee of the second defendant.

Held, allowing the plaintiffs' claim against the first defendant with costs of RM172,215.07 and dismissing the plaintiffs' claim against the second defendant with costs of RM56,565.67:

(1) In the present case although the first defendant had pleaded that she had given the second plaintiff information about vaginal delivery and delivery by way of a caesarean section during their discussions at the antenatal stage and labour, under cross-examination she admitted that she did not offer the second plaintiff the option of a caesarean section. This admission corresponds with the second plaintiff's testimony that the first defendant never offered her a caesarean section. The first defendant's second line of defence that the second plaintiff had misled her on the history of her first pregnancy and delivery during the entire consultation

and had induced her to believe that she was capable of delivering a baby weighing 4.45kg also had no merit. Both the plaintiffs' expert witnesses testified that given the passage of time of almost 11 years between the birth of her elder child and the second plaintiff's pregnancy and the fact that the first defendant was seeing the second plaintiff for the first time, she should have contacted the doctor, who delivered the second plaintiff's first baby, for the details relating to the first baby's birth and weight. Based on the evidence it was clear that the first defendant had not offered to the second plaintiff the option of delivering the first plaintiff by caesarean section during labour, when there was difficulty in delivering the baby's shoulders. In the circumstances, the second plaintiff could not have consented to the risks of a vaginal delivery. It is settled law that the first defendant as a doctor has a duty of care to her patient to advise the patient of the available options of treatment and the corresponding risks and benefits of such options, so as to enable the patient to make an informed decision in giving her consent for the treatment (see paras 46–60, 66–71 & 73–74).

(2) It was the opinion of the plaintiff's expert Dr Lum that based on the available documentation the first defendant had not provided the second plaintiff with any information about her risk factors, namely, foetal macrosomia, the consequences of foetal macrosomia or various aspects of its management. The law is very clear and states that in a pregnancy, the doctor has the duty to advise the mother as to what are her delivery options and to provide her with the necessary information to enable her to make an informed choice. Based on the applicable law, the first defendant had a duty to discuss with the second plaintiff, the pros and cons of the available delivery options, namely vaginal delivery and caesarean section and the risks associated with each delivery option. In this case, the evidence showed that the first defendant had failed to provide the second plaintiff with the necessary information to enable her to make an informed decision as to her choice of delivery and thus fallen below the expected standard of care (see paras 79–81, 84–87, 90 & 93).

(3) Both the expert witnesses, Dr Lum and Dr Murali, testified that in the case of shoulder dystocia during childbirth, the McRoberts manoeuver should be employed to try to deliver the baby. In the present case, although the first defendant claims that the nurses had undertaken the McRobert's manoeuver before she undertook manipulation to deliver the baby, the evidence shows that the first defendant failed to undertake the McRoberts manoeuver correctly and had pulled out the baby's shoulders before the nurses could undertake and complete the McRoberts manoeuver. In the circumstances, the first defendant's failure to undertake the McRoberts maneuver correctly and apply the suprapubic pressure before applying traction to deliver the baby, constitutes a breach of her duty of care. Based on the available evidence, the plaintiffs have

proven on a balance of probabilities that the brachial plexus injury to the baby's shoulder was caused by the first defendant's mismanagement of the shoulder dystocia, by her failure to follow established clinical protocols in dealing with cases of shoulder dystocia and by the manoeuvre she had used in pulling the baby out (see paras 99, 101, 104 & 115–118).

(4) It was clear from the case law that contributory negligence was not based on the claimant's duty of care to the negligent defendant. As such, the second plaintiff would only be contributorily negligent for the harm caused by the first defendant to herself and her baby if she ought reasonably to have foreseen the injuries and she did not take reasonable care of herself. The first defendant and the second plaintiff are in a doctor-patient relationship and the first defendant owed the latter a duty of care to advise her and provide her information of the available delivery options of vaginal delivery and caesarean section and to inform her of the risk and benefits of both options, so as to enable her make to make an informed decision. Whether or not the second plaintiff provides the first defendant with the accurate birthweight of her first born does not negate the first defendant's duty to advise her of the available delivery options and to provide the necessary information in order for her to make an informed choice of the delivery option and to give her informed consent. Based on the doctor-patient relationship between the first defendant and the second plaintiff, it was clear that the first defendant had failed to prove the first limb of the test for contributory negligence, namely that the second plaintiff ought to have reasonably foreseen the harm to herself and to her baby if she gave the first defendant an inaccurate birthweight for her son who was born ten years earlier. The first defendant had not proven the second limb of the test for contributory negligence in that she failed to prove that the second plaintiff had failed to take ordinary care of herself as an ordinary person would in the circumstances. As such, the second plaintiff was not contributorily negligent for the damages caused to her and her baby by the first defendant's negligence (see paras 127–129, 130 & 133–135).

(5) The first defendant failed to support her allegation that the second plaintiff's injuries to her perineum was 'only small fourchette tear' and that the injury was caused by the second plaintiff undertaking excessive physical exercise after delivery or that exercises caused the bleeding. The first defendant had a duty of care to correctly identify, treat and manage the injuries suffered by the second plaintiff as a result of the delivery. However, the first defendant had failed to discharge this duty according to the requisite standard of care and this failure had caused the second plaintiff to suffer further injuries; which injuries required the repair the operation to be undertaken by Dr Hu Shan. Further, the first defendant had failed to discharge the burden of proving her claim that there was a break in the chain of causation from the time the second plaintiff suffered

the perineal and vaginal tears during the delivery and the injuries detailed in Dr Hu Shan's report. Accordingly, it was clear that the first defendant was 100% liable for the injuries suffered by both plaintiffs (see paras 136–137, 144–146 & 151).

(6) Pursuant to the consultant agreement between the first and second defendants, the first defendant was at all material times an independent contractor and not an employee of the second defendant or Pantai Hospital. It is expressly stated in the consultant agreement the first defendant was a licensed and registered medical practitioner, properly qualified in the discipline of obstetrics and gynaecology. Further, as a registered medical practitioner, the obligation to advise, diagnose and treat the second plaintiff including to document her obstetric history is with the first defendant and not with the second defendant, who is the owner of Pantai Hospital KL, a private healthcare facility licensed under the Private Healthcare Facilities and Services Act 1998. The first defendant's arrangement with the hospital was only to provide for the second plaintiff's admission and to provide the necessary facilities and nurses to assist with the labour and delivery. Thus, the relationship between the first and second defendants is not sufficiently akin to employment for the second defendant to be vicariously liable for the first defendant's negligence in managing the second plaintiff's labour and delivering first plaintiff (see paras 160, 181–183 & 186).

(7) In this present case, the second plaintiff had personally chosen the first defendant based on her fertility doctor's (Dr Prashant) advice. Thus, her focus was who was going to be her consultant obstetrician and not the hospital. The second defendant had not assumed a positive duty in respect of the conduct of the first defendant's treatment and management of the plaintiffs. In accordance with the terms of the consultant agreement, the second defendant merely provided the relevant facilities required for her admission, labour and delivery of her baby. As such, it is not possible to impute on the second defendant a positive duty to protect the plaintiffs from injury during the labour and delivery. Accordingly, the second defendant was not in breach of a non-delegable duty of care (see paras 197–198, 202–204 & 207).

(8) Based on the available evidence, the testimony of the experts and established principles of law, the plaintiffs were awarded special damages and general damages. The special damages allowed was RM32,825.80, which included the sum of RM22,597.80 claimed by the plaintiffs for hospital and medical expenses; the sum of RM8,728 as costs of physiotherapy and other rehabilitative treatment incurred by the first plaintiff; the sum of RM500 spent by the plaintiffs during the recovery process; and the sum of RM1,000 for travelling and accommodation expenses. The plaintiffs were also awarded a total sum of RM122,300 as

general damages, which included the sum of RM75,000 for the brachial plexus injury suffered by the first plaintiff; and the sum of RM47,300, being the cost of the first plaintiff's future medical and therapy (see paras 227–231).

(9) The application for the unsuccessful defendant (the first defendant) to pay for the successful defendant's costs ie the second defendant's costs was dismissed. Instead the first defendant was ordered to pay the plaintiff costs in the sum of RM172,215.07, while the plaintiff was ordered to pay the second defendant costs in the sum of RM56,565.67 (see paras 259–263).

[Bahasa Malaysia summary

Baljeet Kaur Grewal a/p Jaswant Singh ('plaintif kedua') melahirkan Gurisha Tarajeet Kaur ('plaintif pertama') di Pantai Hospital Kuala Lumpur, yang dimiliki dan diuruskan pada masa material oleh Pantai Medical Center Sdn Bhd ('defendan kedua'). Plaintif pertama dalam kandungan oleh persenyawaan in-vitro ('IVF'). Selama tiga bulan pertama kehamilannya, plaintif kedua berada di bawah jagaan profesional Dr Prashant dari Pusat Kesuburan KL, yang kemudian merujuknya kepada Dr Premitha Damodaran ('defendan pertama'). Defendan pertama adalah perunding pakar obstetrik dan ginekologi yang bertanggungjawab untuk penjagaan plaintif kedua semasa kehamilan dan waktu bersalin dan yang telah menyambut kelahiran plaintif pertama. Akibat komplikasi semasa melahirkan, plaintif pertama mengalami kecederaan brachial plexus pada bahu kirinya. Selepas kelahirannya, dia didiagnosis dengan kelumpuhan Erb. Plaintif kedua mengalami koyakan tahap kedua pada perineumnya, yang kemudiannya dirawat melalui pembedahani. Plaintif mengaitkan kecederaan yang mereka alami akibat kecuaian defendan pertama. Oleh itu, plaintif mengemukakan tuntutan kecuaian perubatan terhadap defendan. Plaintif mendakwa bahawa defendan pertama dan kedua mempunyai kewajipan untuk menjaga setiap plaintif. Kes plaintif terhadap defendan pertama berdasarkan kepada dua alasan kecuaian yang berbeza yang berkaitan dengan penjagaan antenatal kedua dan pengurusan pekerja plaintif kedua dan proses melahirkan plaintif pertama. Adalah kes plaintif bahawa defendan pertama mempunyai tanggungjawab kepada plaintif kedua untuk menasihatinya mengenai pilihan bersalin dan dia semestinya mengesyaki kemungkinan adanya komplikasi dystocia bahu dan ketidakmampuannya menguruskan komplikasi tersebut. Plaintif juga berpendapat bahawa defendan pertama telah melakukan pengurusan komplikasi dystocia bahu yang salah. Plaintif mengaku bahawa defendan pertama telah menggunakan daya tarikan yang berlebihan untuk membebaskan bahu bayi plaintif pertama semasa kelahirannya yang menyebabkan kecederaan plexus brachial. Plaintif kedua pula berpendapat bahawa kecederaan perineum dan farajnya belum dapat dikenal pasti, dirawat dan diuruskan dengan secukupnya. Plaintif mendakwa bahawa defendan kedua bertanggunggan atas segala kecuaian defendan dan

jururawat serta ejennya dan bahawa defendan kedua mempunyai tanggungjawab kepada pihak plaintif sebagai tugas penjagaan yang tidak dapat dibahagikani. Dalam pemberitahuan mengenai sumbangan dan ganti rugi, defendan pertama menyatakan bahawa dia bergantung pada kepakaran dan kemahiran jururawat dan bidan defendan kedua, yang telah memberikannya forcep yang salah. Dia juga bergantung pada fakta bahawa selepas bersalin plaintif berada di bawah jagaan kakitangan defendan kedua dan bahawa dia tidak bertanggungjawab ke atas kecuaian pegawai dan ejennya oleh defendan kedua. Dalam pembelaannya, defendan kedua menyatakan bahawa ia tidak boleh dipertanggungjawabkan kerana defendan pertama adalah kontraktor bebas dan bukan pekerja defendan kedua.

Diputuskan, membenarkan tuntutan plaintif terhadap defendan pertama dengan kos sebanyak RM172,215.07 dan menolak tuntutan plaintif terhadap defendan kedua dengan kos sebanyak RM56,565.67:

(1) Dalam kes ini walaupun defendan pertama telah mengaku bahawa dia telah memberikan maklumat kepada plaintif kedua mengenai kelahiran melalui faraj dan kelahiran melalui pembedahan caesar semasa perbincangan mereka di peringkat antenatal dan kelahiran, dalam pemeriksaan balas dia mengakui bahawa dia tidak menawarkan pilihan kepada plaintif kedua untuk kelahiran melalui caesar. Pengakuan ini bersesuaian dengan keterangan plaintif kedua bahawa defendan pertama tidak pernah menawarkannya untuk kelahiran caesar. Hujahan pembelaan defendanpertama bahawa plaintif kedua telah menipu mengenai sejarah kehamilan dan kelahiran yang pertama selama keseluruhan perundingan dan telah mendorongnya untuk mempercayai bahawa dia mampu melahirkan bayi seberat 4.45kg juga tidak mempunyai merit. Kedua-dua saksi pakar plaintif memberi keterangan bahawa memandangkan telah berlalunya masa hampir 11 tahun antara kelahiran anak sulungnya dan kehamilan plaintif kedua dan fakta bahawa defendan pertama melihat plaintif kedua untuk pertama kalinya, dia seharusnya menghubungi doktor yang melahirkan bayi pertama plaintif kedua untuk maklumat yang berkaitan dengan kelahiran dan berat bayi pertama. Berdasarkan bukti itu jelas bahawa defendan pertama tidak menawarkan kepada plaintif kedua pilihan untuk plaintif pertama pembedahan caesar semasa bersalin, ketika ada kesulitan dalam proses pengeluaran bahu bayi. Dalam keadaan seperti itu, plaintif kedua tidak dapat menyetujui risiko kelahiran faraj. Sudah menjadi ketetapan bahawa defendan pertama sebagai doktor memiliki kewajipan menjaga pesakitnya untuk menasihati pesakit mengenai pilihan rawatan yang ada dan risiko serta faedah yang sesuai dari pilihan tersebut, sehingga memungkinkan pesakit membuat keputusan yang tepat dalam memberikan persetujuannya untuk rawatan (lihat perenggan 46–60, 66–71 & 73–74).

(2) Adalah pendapat pakar dari pihak plaintif, Dr Lum bahawa berdasarkan dokumentasi yang sedia ada, defendan pertama tidak memberikan maklumat kepada pihak plaintif kedua mengenai faktor risikonya, iaitu makrosomia janin, akibat makrosomia janin atau pelbagai aspek pengurusannya. Undang-undang jelas menyatakan bahawa dalam kehamilan, doktor mempunyai kewajipan untuk memberi nasihat kepada ibu mengenai pilihan bersalin dan memberikan maklumat yang diperlukan untuk membolehkannya membuat pilihan yang tepat. Berdasarkan undang-undang yang terpakai, defendan pertama berkewajipan untuk berbincang dengan plaintif kedua, kebaikan dan keburukan pilihan bersalin yang tersedia, iaitu kelahiran faraj dan kelahiran caesar dan risiko yang berkaitan dengan setiap pilihan bersalin. Dalam kes ini, bukti menunjukkan bahawa defendan pertama gagal memberikan maklumat yang diperlukan kepada plaintif kedua untuk membolehkannya membuat keputusan yang tepat mengenai pilihan bersalin dan oleh itu ia di bawah standard penjagaan yang diharapkan (lihat perenggan 79–81, 84–87, 90 & 93).

(3) Kedua-dua saksi pakar, Dr Lum dan Dr Murali, memberi keterangan bahawa dalam kes dystocia bahu semasa melahirkan, manuver McRoberts harus digunakan untuk berusaha melahirkan bayi tersebut. Dalam kes ini, walaupun defendan pertama mendakwa bahawa jururawat telah melakukan manuver McRobert sebelum dia melakukan manipulasi untuk melahirkan bayi, bukti menunjukkan bahawa defendan pertama gagal melakukan manuver McRoberts dengan betul dan telah menarik bahu bayi sebelum jururawat dapat melakukan dan menyelesaikan manuver McRoberts. Dalam keadaan seperti itu, kegagalan defendan pertama untuk melakukan manuver McRoberts dengan betul dan menerapkan tekanan suprapubik sebelum menggunakan daya tarikan untuk melahirkan bayi, merupakan pelanggaran terhadap tugasnya. Berdasarkan bukti yang ada, pihak plaintif telah membuktikan pada imbangan kebarangkalian bahawa kecederaan plexus brachial pada bahu bayi disebabkan oleh salah urus dystocia bahu defendan pertama, kerana kegagalannya mengikuti protokol klinikal yang telah ditetapkan dalam menangani kes bahu dystocia dan dengan manuver yang digunakannya untuk menarik bayi keluar (lihat perenggan 99, 101, 104 & 115–118).

(4) Adalah jelas dari kes-kes terdahulu bahawa kecuaian penyumbang tidak didasarkan pada kewajipan penuntut untuk menjaga defendan yang cuai. Oleh yang demikian, plaintif kedua hanya bersikap cuai terhadap kemudaratan yang disebabkan oleh defendan pertama terhadap dirinya dan bayi sekiranya dia dapat meramalkan kecederaan itu dan dia tidak menjaga dirinya sendiri. Defendan pertama dan plaintif kedua berada dalam hubungan doktor-pesakit dan defendan pertama bertanggungjawab kepada kedua mereka untuk memberi nasihat

kepadanya dan memberikan maklumatnya mengenai pilihan penyediaan pembedahan faraj dan pembedahan caesar yang tersedia dan memaklumkan kepadanya mengenai risiko dan faedah dari kedua-dua pilihan, untuk membolehkannya membuat keputusan yang tepat. Sama ada plaintif kedua memberikan berat kelahiran anak sulung yang tepat kepada defendan pertama atau tidak, ia tidak menafikan kewajipan defendan pertama untuk menasihatinya mengenai pilihan bersalin yang tersedia dan memberikan maklumat yang diperlukan agar dia dapat membuat pilihan yang tepat bagi bersalin dan k memberi kebenaran kepadanya. Berdasarkan hubungan doktor-pesakit di antara defendan pertama dan plaintif kedua, ia jelas bahawa defendan pertama gagal membuktikan anggota pertama ujian untuk kecuaian penyumbang, iaitu bahawa plaintif kedua semestinya dapat meramalkan bahaya untuk dirinya dan bayisekiranya dia memberi defendan pertama berat kelahiran yang tidak tepat untuk anaknya yang lahir sepuluh tahun sebelumnya. Defendan pertama tidak membuktikan anggota badan kedua ujian atas kecuaian penyumbang kerana dia gagal membuktikan bahawa plaintif kedua gagal mengurus dirinya sendiri seperti yang dilakukan orang biasa dalam keadaan itu. Oleh yang demikian, plaintif kedua tidak bersikap lalai atas kerugian yang dialami olehnya dan bayi kerana kecuaian defendan pertama (lihat perenggan 127–129, 130 & 133–135).

(5) Defendan pertama gagal menyokong dakwaannya bahawa kecederaan plaintif kedua pada perineumnya adalah 'hanya air mata empatchet kecil' dan bahawa kecederaan itu disebabkan oleh plaintif kedua yang melakukan latihan fizikal yang berlebihan setelah melahirkan atau latihan yang menyebabkan pendarahan. Defendan pertama mempunyai kewajipan menjaga untuk mengenal pasti, merawat dan mengurus kecederaan yang dialami oleh plaintif kedua sebagai akibat dari proses kelahiran. Walau bagaimanapun, defendan pertama gagal melaksanakan tugas ini sesuai dengan standard perawatan yang diperlukan dan kegagalan ini telah menyebabkan penggugat kedua mengalami kecederaan lebih lanjut; kecederaan yang memerlukan rawatan melalui pembedahan harus dilakukan oleh Dr Hu Shan. Selanjutnya, defendan pertama gagal melepaskan beban membuktikan tuntutannya bahawa rantaian penyebab sejak penggugat kedua menderita air mata perineum dan faraj semasa melahirkan dan kecederaan yang diperincikan dalam laporan Dr Hu Shan itu terputus. Oleh itu, jelas bahawa defendan pertama bertanggungjawab 100% atas kecederaan yang dialami oleh kedua-dua plaintif (lihat perenggan 136, 137, 144–146 & 151).

(6) Berdasarkan perjanjian perunding di antara defendan pertama dan kedua, defendan pertama pada setiap masa adalah kontraktor bebas dan bukan pekerja defendan kedua atau Hospital Pantai. Dalam perjanjian Pperunding dinyatakan secara tegas bahawa defendan pertama adalah seorang pengamal perubatan berlesen dan berdaftar, berkelayakan dalam

bidang kebidanan dan ginekologi. Selanjutnya, sebagai pengamal perubatan berdaftar, kewajiban untuk menasihati, mendiagnosis dan merawat plaintif kedua termasuk untuk mendokumentasikan sejarah kelahirannya adalah dengan defendan pertama dan bukan dengan defendan kedua, yang merupakan pemilik Hospital Pantai KL, sebuah kemudahan penjagaan kesihatan swasta dilesenkan di bawah Akta Kemudahan dan Perkhidmatan Penjagaan Kesihatan Swasta 1998. Perjanjian defendan pertama dengan hospital hanya untuk membenarkan kemasukan plaintif kedua dan menyediakan kemudahan dan jururawat yang diperlukan untuk membantu proses bersalin. Oleh itu, hubungan antara defendan pertama dan kedua tidak sama dengan pekerjaan untuk menyebabkan defendan kedua untuk bertanggungjawab atas kecuaian defendan pertama dalam menguruskan pekerja plaintif kedua dan untuk proses bersalin plaintif pertama (lihat perenggan 160, 181–183 & 186).

(7) Dalam kes ini, plaintif kedua secara peribadi memilih defendan pertama berdasarkan nasihat doktor kesuburannya (Dr Prashant). Oleh itu, tumpuannya adalah siapa yang akan menjadi pakar perbidanan dan bukan hospital. Defendan kedua tidak memikul tugas positif sehubungan dengan perlakuan dan pengurusan defendan pertama terhadap pihak plaintif. Sesuai dengan syarat-syarat perjanjian perunding, defendan kedua hanya menyediakan kemudahan yang diperlukan untuk kemasukan, kelahiran dan kelahiran bayinya. Oleh yang demikian, tidak mungkin untuk defendan kedua mempunyai tugas positif untuk melindungi plaintif dari kecederaan semasa bersalin dan kelahiran. Oleh itu, defendan kedua tidak melanggar tugas penjagaan yang tidak dapat dibahagikan (lihat perenggan 197–198, 202–204 & 207).

(8) Berdasarkan bukti yang ada, keterangan ahli dan prinsip undang-undang yang tetap plaintif-plaintif diberikan ganti rugi khas dan ganti rugi am. Kerugian khas yang dibenarkan ialah RM32,825.80, yang merangkumi sejumlah RM22,597.80 yang dituntut oleh plaintif untuk perbelanjaan hospital dan perubatan; sejumlah RM8,728 sebagai kos fisioterapi dan rawatan pemulihan lain yang ditanggung oleh plantif pertama; sejumlah RM500 yang dibelanjakan oleh plaintif semasa proses pemulihan; dan sejumlah RM1,000 untuk perbelanjaan perjalanan dan penginapan. Plaintif juga diberikan sejumlah RM122,300 sebagai ganti rugi am, yang merangkumi sejumlah RM75,000 untuk kecederaan plexus brachial yang dialami oleh plaintif pertama; dan sejumlah RM47,300, menjadi kos perubatan dan terapi masa depan penggugat pertama (lihat perenggan 227–231).

(9) Permohonan defendan yang tidak berjaya (defendan pertama) untuk membayar kos defendan yang berjaya iaitu kos defendan kedua ditolak.

Sebaliknya defendan pertama diperintahkan untuk membayar kos kepada plaintif sebanyak RM172,215.07, sementara plaintif diperintahkan untuk membayar kos kepada defendan kedua sebanyak RM56,565.67 (lihat perenggan 259–263).]

Cases referred to

Davies v Swan Motor Co (Swansea) Ltd [1949] 2 KB 291, CA (refd)
Donoghue v Stevenson [1932] AC 562, HL (refd)
Besterman v British Motor Cab Company, Limited [1914] 3 KB 181, CA (distd)
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Bolitho (administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority [1997] 4 All ER 771; [1998] AC 232, HL (folld)
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Elizabeth Chin Yew Kim & Anor v Dato' Ong Gim Huat (sued as public officer of Hospital Lam Wah Ee) and other appeals [2017] 1 MLJ 328; [2017] 2 CLJ 509, CA (refd)
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Fletcher v Autocar & Transporters, Ltd [1968] 1 All ER 726; [1968] 2 QB 322, CA (refd)
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593; [2007] 1 CLJ 229; [2007] 1 AMR 621, FC (refd)
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Inas Faiqah bt Mohd Helmi (an infant suing through her father and next friend, Mohd Helmi bin Abdul Aziz) v Kerajaan Malaysia & Ors [2016] 2 MLJ 1; [2016] 2 CLJ 885, FC (refd)
Jones v Livox Quarries Ltd [1952] 2 QB 608, CA (refd)
Lewis v Denye [1939] 1 All ER 310; [1939] 1 KB 540, CA (refd)
McDermott v InHealth Ltd [2018] EWHC 1835 (QB), QBD (distd)
Mohamud v WM Morrison Supermarkets plc [2016] AC 677, SC (refd)
Montgomery v Lanarkshire Health Board (General Medical Council intervening) [2015] UKSC 11; [2015] AC 1430; [2015] 2 WLR 768, SC (refd)
Natahlie Nordberg v Quah Thong Sai & Anor [2014] MLJU 1736; [2017] 10 CLJ 209; [2015] AMEJ 339, HC (refd)
Ong Ah Long v Dr S Underwood [1983] 2 MLJ 324; [1983] 2 CLJ 198; [1983] CLJ Rep 300, FC (refd)
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Rogers v Whitaker (1992) 175 CLR 479, HC (refd)

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Management Corporation Strata Title Plan No 3322 v Tiong Aik Construction Pte Ltd and another [2016] 4 SLR 521; [2016] SGCA 40, CA (refd)
Various Claimants v Catholic Child Welfare Society and others [2013] 2 AC 1, SC (folld)
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Yew Wan Leong v Lai Kok Chye [1990] 2 MLJ 152; [1990] 1 CLJ 1113; [1990] 1 CLJ Rep 330, SC (refd)
Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017] 5 MLJ 438; [2017] 8 CLJ 605, FC (folld)

Legislation referred to

Private Healthcare Facilities and Services Act 1998
Rules of Court 2012 O 56 r 7(1), (2), O 59 rr 3(2), 7(1), 7(2)

PS Ranjan (MS Dhillon, Karthi Kanthabalan and Jeremy Balang with him) (PS Ranjan & Co) for the plaintiff.
Sharon Palani (Sreether Sundaram with her) (Murali B Pillai & Assoc) for the first defendant.
Felix Raj (Ahmad Aizek with him) (Felix Raj Chambers) for the second defendant.

Faizah Jamaludin J:

1. INTRODUCTION

[1] This is a medical negligence claim brought by the first plaintiff, Gurisha Tarajeet Kaur ('Gurisha') and her mother, the second plaintiff, Baljeet Kaur Grewal d/o Jaswant Singh ('Mdm Baljeet') against the first defendant, Dr Premitha Damodaran ('D1'), a consultant obstetrician and gynaecologist practicing at Pantai Hospital Kuala Lumpur ('Pantai Hospital KL') and the second defendant, Pantai Medical Centre Sdn Bhd ('Pantai') ('D2') who was at the material time, the owner and manager of Pantai Hospital KL.

A **[2]** Mdm Baljeet gave birth to Gurisha on 14 May 2014 at Pantai Hospital KL. As a result of complications during delivery, Gurisha suffered brachial plexus injury to her left shoulder and Mdm Baljeet suffered a tear to her perineum. One of the disputes in this case, is whether the tear to Mdm Baljeet's perineum was 'only a small fourchette tear' or a second-degree tear.

B

[3] D1 was the consultant obstetrician and gynaecologist responsible for Mdm Baljeet's care during her pregnancy and labour and who had delivered baby Gurisha. The plaintiffs attribute the injuries suffered to D1's negligence.

C

[4] The plaintiffs' case of medical negligence against D1 is premised on lack of documentation, failure to give adequate advice, information and/or warning, failure to take proper informed consent, failure to perform a complete and accurate McRoberts manoeuvre, and using excessive force in handling the delivery.

D

[5] The plaintiffs claim that both D1 and D2, and each of them, owed independent duties of care to the plaintiffs. They also claim that D2 owed them a non-delegable duty of care and is vicariously liable for D1's wrongful acts and omissions.

E

[6] The trial of this case took place initially over 14 non-consecutive days. The plaintiffs called as their expert witnesses, Dr Milton Lum Siew Wah, a consultant obstetrician and gynaecologist ('SP5') and Dr Kavitha Uma Ratnalingam, a rehabilitation physician ('SP6'). They called five witnesses of facts, namely, Dr Chai Pei Fan, the consultant paediatrician who saw Gurisha after her birth and who had diagnosed her as suffering from Erb's palsy ('SP1'); Datin Dr Hu Shan, a consultant obstetrician and gynaecologist at Damansara Specialist Centre who had conducted the operation to repair the tear to Mdm Baljeet's perineum ('SP2'); Mdm Baljeet herself ('SP3'), Mdm Baljeet's husband and Gurisha's father, Mr Taranjeet Singh s/o Bhagwan Singh ('SP4') and Mdm Baljeet's father, Datuk Dr Jaswant Singh ('SP7').

F

G

[7] D1 called as her expert witnesses, Dr Muralitharan Ganesalingam, a consultant obstetrician and gynaecologist ('SD7') and Dr Theva Raj Ponnudurai, a consultant in rehabilitation medicine ('SD2'). D1's witnesses of fact were herself ('SD1'), Dr Kamaljit Kaur d/o Harbans Singh, a consultant obstetrician and gynaecologist ('SD3'), Mdm Ng Soo Ling, a retired nurse ('SD4'), Mdm Sarah Prem Kumar, a physiotherapist ('SD5') and Miss Elisabeth d/o Pithchaimuthi, a consultant lactation nurse ('SD6').

H

I

[8] The plaintiffs' expert witness, Dr Milton Lum, is a consultant obstetrician and gynaecologist of 36 years' experience. Among the previous positions he held were President of the Malaysian Medical Association and

President of the Obstetrical and Gynaecological Society of Malaysia. He is a regular columnist of The Star newspaper and he has written 18 books and published and presented more than 120 papers nationally and internationally.

[9] D1's expert witness, Dr Muralitharan Ganesalingam ('Dr Murali'), is a Senior Consultant and Head of Department of Obstetrics and Gynaecology Hospital Ampang. He has practiced in the field of obstetrics and gynaecology since 1990 and is involved in the training of medical students at Universiti Sains Islam Malaysia and University Tunku Abdul Rahman in the field of obstetrics and gynaecology. He is also an examiner for final year students in both universities and Melaka Manipal Medical College.

[10] D2's only witness was its former chief executive officer, Encik Anwar bin Anis ('SD8').

[11] After both parties had closed their respective cases, the plaintiffs filed an application ('encl 149') for leave to reopen the case because post-trial Gurisha's physiotherapist had informed Mdm Baljeet and her husband that Gurisha had developed a mild scoliosis to the spine, which finding of scoliosis was confirmed by Dr Kavitha Uma Ratnalingam (SP6).

[12] At the hearing of encl 149 on 1 March 2019, this court granted the plaintiffs leave to reopen their case limited only to the issue relating to the scoliosis they claimed to be suffered by Gurisha. They were allowed to recall Dr Kavitha and both defendants were given leave to call their own expert witnesses during trial relating to the scoliosis issue.

[13] Trial was re-opened and held for another day as regards the issue of Gurisha's alleged scoliosis. D1 called Dato Dr Sivananthan K Shanmugam ('SD9'), a consultant orthopaedic surgeon, as her expert witness and the plaintiffs recalled Dr Kavitha to testify on the issue. D2 did not call any witness to testify on their behalf on this issue.

[14] On 4 October 2019, this court allowed the plaintiffs' claim of medical negligence against D1 but dismissed their claim against D2. This court found that D1 was 100% liable for the injuries suffered by the first and seconds plaintiffs.

[15] After this court had delivered its decision on liability and quantum of damages, counsel for the plaintiffs, Mr MS Dhillon, requested that the issue of costs be dealt with after the conclusion of proceedings under O 59 r 7(1) and (2) of the Rules of Court 2012 ('the ROC'). Mr Dhillon also informed this court that the plaintiffs are seeking a Sanderson order for D1 to pay D2's costs instead of the plaintiffs.

[16] After hearing the submissions of counsels, on 4 November 2019, this court made an order for costs and dismissed the plaintiffs' application for a Sanderson order. I found that it was not appropriate to grant a Sanderson order in this case as it was not fair and just in the circumstances.

[17] This judgment sets out in full my reasons for this court's decision in respect of liability and quantum as regards the plaintiffs' claim for medical negligence. It also sets out in full the reasons for my dismissal of the plaintiffs' claim for a Sanderson order.

2. MATERIAL FACTS

[18] Mdm Baljeet's pregnancy, which is the subject matter of these proceedings, was her second pregnancy. Her first pregnancy was in 2003. She had delivered her eldest son Soheil Taranjeet Singh ('Soheil') on 26 October 2013. The delivery was undertaken by Dr Gunasegaran at the Damansara Specialist Hospital at 42 weeks after an induction and subsequent vacuum delivery.

[19] Gurisha was conceived by in vitro fertilisation ('IVF') from a frozen embryo transfer. Mdm Baljeet testified that this second pregnancy was a precious pregnancy as the baby was conceived after two IVF attempts — the first being unsuccessful. During the first three months of her pregnancy, Mdm Baljeet was under the professional care of Dr Prashant of the KL Fertility Centre. She was then referred by Dr Prashant to D1. Mdm Baljeet said that her choice of D1 was because of Dr Prashant's recommendation.

[20] Mdm Baljit first consulted D1 on 20 November 2013 and again on 12 December 2013, 7 January 2014, 7 February 2014, 8 March 2014, 27 March 2014, 11 April 2014, 22 April 2014, 30 April 2014, 7 May 2014 and 12 May 2014. The records show that her blood pressure was within normal limits and that uterine growth, assessed by physical examination and ultrasound, was compatible with her dates. During the consultation on 7 May 2014, at 38+ weeks gestation, D1 noted in her medical records that Mdm Baljeet was 'not keen to prolong pregnancy till past dates' and was 'keen on induction'. D1 informed Mdm Baljeet that she will be away from 16–19 May 2014. Her notes on 7 May 2014 states 'Informed I am not around from 16/05–19/05'.

[21] On 12 May 2014, at 39 weeks four days gestation, Mdm Baljeet consulted D1 and informed her that she had diarrhoea and had vomited overnight. On examination, Mdm Baljeet was found to be dehydrated. Her blood pressure was 127/72mmHg and her weight was 92.5kg. Vaginal examination findings were the same as during the previous consultation. The

estimated foetal weight was 3.8–4 kg. D1's notes state that there was a discussion about induction or waiting until 41 weeks gestation. She noted 'induction as Cx still unfavourable. — Needs overnight Prostin, then Syntocinon. If still fails, for LSCS (not keen). Want to try normal. Leave alone — await labour or induce at 41/52. Prefers induction with Prostin. Admit 13/05/14 for Prostin'. According to the ultrasound report, the estimated foetal weight was 3.753 plus/minus 0.548kg and 3.649 plus/minus 0.533kg.

[22] On 13 May 2014, at 39 weeks five days gestation, Mdm Baljeet was admitted into Pantai Hospital KL at 2215 hours for induction of labour. D1 documented 'big baby' at 40 weeks. She examined Mdm Baljeet at 2240 hours.

[23] On 14 May 2014, at 0800 hours, Mdm Baljeet received an epidural by Dato Dr Damodaran. At 0830 hours, her membranes were artificially ruptured. Mdm Baljeet was nursed in the left lateral position and was given intravenous Hartmann's solution. At 1020 hours, D1 saw Mdm Baljeet and instructed the nurses that Oxytocin could be started after 15 minutes. At 1045 hours, Oxytocin was commenced. Mdm Baljeet was recorded as having one mild contraction every 5–6 minutes. At 1430, D1 conducted a vaginal examination on Mdm Baljeet, which revealed a cervical dilatation of 7cm. She was then catheterized and informed that there was 'good progress'. At 1535 hours, Mdm Baljeet requested for an epidural 'top-up' as the contractions were getting more frequent. Dato Dr Damodaran saw her again and prescribed Naropin.

[24] On 14 May 2014 at 1745 hours, D1 examined Mdm Baljeet again and note that she was fully dilated and was asked to commence 'pushing'.

[25] Gurisha was delivered on 14 May 2014 at 1825 hours at 39 weeks six days gestation by way of a Neville Barnes forceps delivery. After her birth, she was diagnosed as having Erb's palsy. She suffered brachial plexus injuries to her left arm. Mdm Baljeet suffered a second-degree tear to her perineum, which was later repaired by Dr Hu Shan (SP2) by way of an operation.

3. ISSUES AT TRIAL

[26] In summary, the main issues raised by the plaintiffs against D1 are as follows:

(a) whether D1 had a duty to advise Mdm Baljeet on her delivery options;

(b) whether D1 should have advised Mdm Baljeet on the risks and benefits of a caesarean section as opposed to a vaginal delivery;

(c) whether D1 should have disclosed to Mdm Baljeet that she had insufficient experience in managing shoulder dystocia cases;

(d) whether D1 should have suspected the possibility of a shoulder dystocia complication;

(e) whether D1 had undertaken correct management of the shoulder dystocia complication;

(f) whether D1 should have contacted Dr Gunasegaran so as to get details of Soheil's birth and weight; and

(g) whether Mdm Baljeet's perineal and vaginal injuries had been sufficiently identified, treated and managed.

[27] The plaintiffs claim against D2 are as follows:

(a) D2 is vicariously liable for any negligence of D1;

(b) D2 is vicariously liable for its nurses and agents; and

(c) D2 owed a non-delegable duty of care to the plaintiffs?

[28] D1 and D2 have each issued a notice for contribution and indemnity against each other, which are summarised below:

(a) D1 in her notice of contribution and indemnity raised the following issues:

(i) at all material times, D1 had relied on the expertise and skill of D2's nurses and midwives;

(ii) the nurses and midwives had supplied D1 a wrong set of forceps;

(iii) that an infusion pump was defective, resulting in a more than half an hour wait;

(iv) that Gurisha was wrongly described as a male baby;

(v) that post-delivery Gurisha and Mdm Baljeet were under the care of D2's staff members; and

(vi) D1 was not liable for D2's negligence of and of its servants and agents;

(b) D2's case is that if D1 is found to be negligent, D2 should not be held liable as D1 is an independent contractor and not an employee of D2.

4. CLAIM AGAINST DR PREMITHA DAMODARAN (D1)

[29] The plaintiffs advanced two distinct grounds of negligence against D1: they relate to (a) Mdm Baljeet's ante-natal care; and (b) the management of Mdm Baljeet's labour and Gurisha's delivery.

[30] The particulars of D1's negligence pleaded by the plaintiffs are as follows: **A**

(a) ante-natal care:

(i) D1 failed to discuss with Mdm Baljeet and her husband and provide them with sufficient advice on the risks and benefits of all delivery options so as to allow Mdm Baljeet and her husband to make an informed decision on the delivery options; **B**

(ii) when Mdm Baljeet expressed a desire to attempt a vaginal delivery and was not keen on a caesarean delivery, D1 failed to discuss, explain and advise Mdm Baljeet and her husband of the risks and benefits of the various delivery options. Instead D1 encouraged Mdm Baljeet to undergo vaginal delivery; **C**

(iii) D1 failed to advice Mdm Baljeet and husband that Gurisha in utero was at higher risk of becoming macrosomic baby; and **D**

(iv) D1 failed to advise Mdm Baljeet and her husband that macrosomia was a reliable predictor of shoulder dystocia and was likely to occur in this case;

(b) management of labour and delivery: **E**

(i) D1 undertook insufficient monitoring of the labour after having induced the labour;

(ii) D1 failed to anticipate the material risk of shoulder dystocia occurring; **F**

(iii) D1 failed to have sufficient and adequate obstetric assistants or nurses available to assist when the shoulder dystocia occurred in baby Gurisha;

(iv) D1 failed to execute the McRobert's manoeuvre correctly and accurately; **G**

(v) D1 undertook the McRobert's procedure with insufficient assistance from the obstetric team;

(vi) D1 applied excessive traction to free baby Gurisha's shoulder during her delivery which caused the brachial plexus injury; **H**

(vii) D1 failed to call, without delay, for appropriate assistance when the shoulder dystocia occurred; and

(viii) D1 failed to have the correct set of forceps when undertaking the delivery. **I**

[31] The plaintiffs contend that Gurisha's birth was complicated by the shoulder dystocia emergency. Also, following a failed attempt in properly

executing a McRoberts manoeuvre, D1 had used excessive and unjustifiable traction in delivering Gurisha causing injuries to both plaintiffs.

5. THE LAW ON MEDICAL NEGLIGENCE

[32] It is settled law in an action founded on the tort of negligence, a plaintiff must prove that: (i) the defendant owes him a duty of care; (ii) the defendant breached that duty of care; (iii) the plaintiff suffered damages as a result of the breach; and (iv) the damages are not too remote.

(a) Duty of Care

[33] The root principle of English common law negligence applied in Malaysia is to 'take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour' per Lord Atkin in *Donoghue v Stevenson* [1932] AC 562 at p 580.

[34] The duty of care owed by a doctor to his patient; arises out of his relationship with his patient. Siti Norma Yaacob FCJ (as she then was) in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229; [2007] 1 AMR 621, explained the principle as: 'Without the doctor and patient relationship, there is no duty on the part of the doctor to diagnose, advice and treat his patient'.

[35] The Federal Court in *Foo Fio Na* cited with approval the description of the common law duty of care of doctors by Lord Hewart CJ in *R Bateman* [1925] All ER Rep 45; (1925) 94 LBKB 79:

> If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward.

(b) Standard of care

(i) The Bolam test

[36] The locus classicus of the test for the standard of care required of a doctor or any other person professing some skill or competence is the direction to the jury given by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, where he said:

> But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. *The test is the standard of the ordinary skilled man exercising and professing to have that special skill.*
>
> ...
>
> *A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that medical act* ... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion that takes a contrary view. (Emphasis added.)

[37] In essence, the *Bolam* test is that the law imposes a duty of care on doctors vis a vis their patients but the applicable the standard of care is a matter of medical judgment. The *Bolam* test is a singular test of a doctor's standard of care owed by a doctor to his patient. The test does not make any distinction between diagnosis, treatment or the duty to advise of risks.

[38] As explained by Raus Sharif CJ in *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438; [2017] 8 CLJ 605 (FC) under the *Bolam* test it is the medical practitioners who have the final say, and not the courts, as to whether a doctor had met the applicable standard of care in his diagnosis or treatment a patient or in the provision of information or advice to a patient. His Lordship said as follows:

> The approach of the *Bolam* test practically meant that while the law imposed a duty of care, the standard of care owed by a doctor to a patient is left to the medical fraternity ... In other words, the medical practitioners had the final say whether there was negligence and not the courts.

(ii) The tests in *Rogers v Whitaker* and *Bolitho*

[39] In *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, the House of Lords considered the specific issue of a doctor's duty to advise his patient as oppose to his duty to diagnose and treat.

[40] The majority of the Law Lords rejected any change to the *Bolam* test and held that it applied to all aspects of a doctor's duty to his patient. However, Lord Scarman declined to apply the *Bolam* test to a doctor's duty to advise. In his dissenting judgment, Lord Scarman said:

> In my view *the question whether or not the omission to warn* constitutes a breach of the doctor's duty of care towards his patient *is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the*

> *time*, though both are, of course, relevant considerations, *but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes*.
>
> ...
>
> If failure to warn of risk is actionable in English law, it must be because it is in the circumstances a breach of the doctor's duty of care: in other words, the doctor must be shown to be negligent ... *If, however, the Bolam principle is to be applied to the exclusion of any other test to advice and warning, there will be cases in which a patient who suffers injury through ignorance of a risk known to the doctor has no remedy.* Is there any difficulty in holding that the doctor's duty of care is sufficiently extensive to afford a patient in that situation a remedy, if as a result she suffers injury or damage? I think not. (Emphasis added.)

[41] Lord Scarman's dissenting view in *Sidaway* was later developed in by the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR 479 and by the House of Lords in *Bolitho (administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority* [1997] 4 All ER 771; [1998] AC 232.

[42] In *Rogers v Whitaker*, the High Court of Australia held that the duty of a medical practitioner to exercise reasonable skill and care in the provision of professional advice and treatment is a single comprehensive duty. But the factors according to which a court determines whether there was a breach of the requisite standard of care varies according to whether the case involves diagnosis, treatment or provision of information or advice. The Australian High Court held:

> There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, *all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended*. (Emphasis added.)

[43] The effect of the decision in *Rogers v Whitaker* is that as regards a doctor's duty to advise and the scope of that duty is to be decided by the courts and not medical practitioners. The Australian High Court in *Rogers v Whitaker* had established a 'materiality test' in place of the *Bolam* test as regards the duty to advise.

[44] In *Bolitho*, the House of Lords qualified the *Bolam* test by making the body of professional opinion sanctioning the doctor's conduct capable of

withstanding logical analysis. If the professional opinion does not withstand logical analysis, the court can hold that the body of opinion as not being reasonable or responsible. As explained by Raus Sharif CJ in *Zulhasnimar bt Hasan Basri*:

> [44] In *Bolitho*, the qualification to *Bolam* test was that, if the body of medical opinion does not withstand logical analysis, the court may hold that it is not reasonable or responsible and may then depart from it. In effect, *Bolitho* retained the *Bolam* test for all purposes in respect of medical negligence, but made it subject to the condition that for the expert opinion to be acceptable to the courts, it must be capable of withstanding logical analysis.

[45] The House of Lords in *Bolitho* was of the view that the factors to determine whether there was a breach of a doctor's duty of care to his patient varied according to whether a doctor has a legal duty to warn a patient of a material risk inherent in proposed treatment. A risk is material if a reasonable person in the patient's position would, if warned of the risk, be likely to attach significance to it.

6. ANALYSIS

(a) Did D1 inform Mdm Baljeet of caesarean section option?

[46] D1 in para 10 of her amended defence pleads that she had given Mdm Baljeet during their discussions at the antenatal stage and labour, information about vaginal delivery and delivery by way of a caesarean section. She also pleads that she had discussed the option of caesarean section in the event Mdm Baljeet needed it.

[47] However, under cross-examination, D1 admitted that she did not offer Mdm Baljeet the option of a caesarean section. She also admitted that her pleading in para 10 of her amended defence claiming that she had discussed the option of a caesarean section with Mdm Baljeet is not true. Excerpts of D1's cross-examination by the plaintiffs' counsel on this issue are reproduced below:

> Plaintiff's counsel: Doctor, in regard to relevance, we would like to see the documents first before we can comment on that. *Now, when this issue about use of forceps arose, did you, at the same time, discuss the need for a caesarean section?*
>
> D1: *There was no need for a caesarean section at that time because the head was just sitting there …*
>
> Plaintiff's counsel: *Doctor, short answer is, did not discuss, right?*
>
> D1: *No, I did not … I did not offer a caesarean section*
>
> Plaintiff's counsel: This was put at your instructions. *So that is not true?*
>
> D1: *Yes.*

(Emphasis added.)

[48] D1's admission corresponds with Mdm Baljeet's testimony that D1 never offered her a caesarean section. Mdm Baljeet when questioned on this issue by D1's counsel during cross-examination, answered as follows:

> D1's counsel: So when she offered you C-section, why did you deny it?
>
> P2: *She did not offer me a C-section, not at any point during the discussion or at any point during the delivery process itself.*
>
> ...
>
> D1's counsel: I put to you Madam, during the delivery, because there was a difficulty in delivering the shoulders, you were informed by Dr Premitha an option of having a forceps or vacuum and she chose the option of forceps because a vacuum would pose a higher risk for your baby.
>
> P2: This was not shared with us.
>
> D1's counsel: I put to you, that information was told to your husband and you and you had consented for a forceps delivery? Your husband or yourself consented to a forceps delivery.
>
> P2: We told the doctor to do whatever she thinks is right.
>
> D1's counsel: *But at the same time, when the doctor offered a lower section caesarean section, you were not keen?*
>
> P2: *At what point did she offer this? It was not offered to us in the delivery room at all.* (Emphasis added.)

[49] Significantly, D1 raised a second line of defence to the plaintiffs' claim that she did not give Mdm Baljeet any information on the alternative possibility of delivery by elective caesarean section and the risk of shoulder dystocia associated with macrosomic babies and vaginal deliveries.

[50] In her first line of defence, D1 pleads that she had given Mdm Baljeet and her husband advice on the alternative possibility of delivery by elective caesarean section.

[51] In contrast to her first line of defence, in this second line of defence, D1 says that she did not give Mdm Baljeet any information on alternative delivery by way of a caesarean option because based on Soheil's birth weight, Mdm Baljeet was able to deliver a larger baby through vaginal delivery.

[52] D1 had recorded Soheil's birthweight as 4.54kg, which she says was informed to her by Mdm Baljeet and her husband during their first consultation with her. Mdm Baljeet and her husband in their respective witness

statements state that Soheil's birth weight was approximately 4kg. Both Mdm Baljeet and her husband deny that they had informed D1 that Soheil's birthweight was 4.54kg.

[53] The documents produced during the trial showed that Soheil's birth weight was in fact recorded as 3.8kg by Dr Gunasegaran, the doctor who had delivered him.

[54] Based on this new information, D1 then amended her Defence to include pleas in paras 17A–17E of her amended defence that Mdm Baljeet was negligent and/or reckless and/or innocently and/or without due care, had misled D1 on the history of her first pregnancy and delivery during the entire consultation; that Mdm Baljeet had induced D1 to believe that she was capable of delivering a baby weighing 4.45kg per vaginum and that D1 relied on the history given by Mdm Baljeet and proceeded to consider all reasonable available delivery options for her.

[55] Consistent with D1's second line of defence, D1's counsel, Ms Sharon Palani, argues that there is no evidence before this court to show that Mdm Baljeet ought to have been given a caesarean option given that she had previously been able to deliver per vaginum, a much larger baby. Ms Palani submits that the diagnosis and treatment rendered by D1 was based entirely on the history by Mdm Baljeet of her capacity. Ms Palani says that having baby Gurisha stuck during the procedure was never anticipated and it became and emergency which D1 had to deal with during the delivery. Learned counsel further submits that the facts of this case 'are pretty straightforward except to the twist that the Mother gave an erroneously wrong history about her capability to deliver per vaginum'.

[56] Both the plaintiffs' expert witness, Dr Lum, and D1's expert witness, Dr Murali, testified that given the passage of time of almost 11 years between Soheil's birth and Mdm Baljeet's pregnancy and the fact that D1 was seeing Mdm Baljeet for the first time, D1 should have contacted Dr Gunasegaran for the details relating to Soheil's birth and weight.

[57] During cross-examination, plaintiffs' counsel, Mr MS Dhillon, had asked Dr Murali the question of obtaining consent to contact Dr Gunasegaran for the details of Mdm Baljeet's earlier delivery. An excerpt of the question and Dr Murali's answer is reproduced below:

> Plaintiffs' counsel: And where there has been a passage of time, the attending doctor, with greater knowledge, experience and wisdom in the field of obstetrics, can tell the patient. 'Do you mind if I contact Dr Gunasegaran to get details regarding the previous delivery?

Dr Murali: Yes

Plaintiffs' counsel: *That would be the right thing to do, right Doctor?*

Dr Murali: *Yes ...*

(Emphasis added.)

[58] However, Dr Murali during re-examination, which took place after an adjournment of the proceedings, recanted on the earlier testimony he gave during cross-examination. During re-examination by D1's counsel, Dr Murali changed his testimony and said that since D1 had obtained a detailed history from Mdm Baljeet, he thinks that 'there was no reason for her to contact any other doctor to find out what had happened in the previous pregnancy'. When asked by Ms Palani whether by his answer during cross-examination, he was 'suggesting that Dr Premitha should have got Baljeet's permission and obtain (sic) the history from Dr Guna', Dr Murali answered:

> No, I am not, the question was a *generic* question. In the event that there is an inadequate amount of history, then you could ask the patient, 'Do you mind if I ask the previous obstetrician regarding details of the previous birth'. But in this instance, there was adequate amount of history there, there was no need for Dr Premitha to ask Dr Guna for further details because the information was already available.

[59] When asked further by Ms Palani, what he meant when he agreed with plaintiffs' counsel that 'that would be the right thing to do', Dr Murali answered:

> I don't think that question was *specific* for the case in hand right now, it was a *generic* question. In a *generic* question, if I have a patient from whom I am unable to obtain adequate amount of history or details of the previous birth, then it would be prudent for me to ask her for permission to speak to her previous obstetrician to obtain the details. In this instance, there was adequate amount of history. Therefore, that did not come about ... (Emphasis added.)

[60] Dr Murali in his answer during re-examination had failed to take into account that D1 had earlier testified that she had in fact asked Mdm Baljeet if she had any documents regarding Soheil's delivery despite claiming that she had obtained a detailed history of his birth. Below is the excerpt of the D1's answer on this issue during cross-examination:

> Plaintiffs' counsel: Did you see any reason to ask the parents to give some written document regarding the first baby's weight?
>
> D1: *As I had mentioned earlier yesterday that I did ask and they said that it has been 10 years ago and they were not sure where the records were.*

Plaintiffs' counsel: So you had asked because you thought it would be relevant to confirm the information? A

D1: *Any additional information is good* ...

(Emphasis added.)

B

[61] Dr Lum testified that if he were the attending obstetrician, he would have discussed the management and the recommendation of a caesarean section with the patient. At para 4.9 on p 4 of his expert report, Dr Lum wrote the following based on D1's notes in Bundle D p 28 of the common bundle of documents: C

4.9 On 12 May 2014, at 39 weeks 4 days gestation, BKG consulted Dr PD. She had diarrhoea and vomiting overnight. On examination, BKG was dehydrated. Her blood pressure was 127/72mmHg and weight 92.5kg. Vaginal examination findings were the same as in the previous consultation. The estimated foetal weight was 3.8–4kg. There was discussion about induction or waiting until 41 weeks gestation. Dr PD documented 'induction as Cx still unfavourable. Needs overnight Prostin, then Syntocin. If still fails, for LSCS (not keen). Wants to try normal. Leave alone — await labour or induce 41/52. Prefers induction with Prostin. Admit 13/05/14 for Prostin. (HID page 207). According to the ultrasound report, the estimated foetal weight was 3.753 plus/minus 0.548kg and 3.649 plus/minus 0.533kg (HID page 197). D E

[62] Dr Lum was asked by the plaintiffs' counsel, Mr PS Ranjan, given what was written by D1, in what respect was a caesarean section to be considered? He replied that: F

I think most obstetricians know with increasing birth order, the birth weight of the baby will increase, that is the first baby, if says weighs 3kg, the likelihood of the second baby would be heavier than that ... So if she had, in this instance, a baby of 4.54kg that was in the notes that was given to me, but now we know that its 3.8 kg and *if you estimate that the foetal weight is 3.8kg to 4 kg, certainly there should be a discussion with the patient about elective caesarean section to avoid any of the risk of problems that are associated with a big baby*. I do note that here the patient is not keen on a caesarean section. But having said that, *an obstetrician has a duty to emphasize this if the obstetrician feels strongly that a caesarean section is necessary* and I think most patients would accept that sort of recommendation, although in general most pregnant ladies do not want a caesarean section. But having said that, as I said an obstetrician, if he feels that a caesarean section is necessary, that recommendation is usually adhered to, the advice is adhered to by patients. (Emphasis added.) G H

[63] When asked to comment on the after-delivery notes in Bundle D p 29, where it was written under the heading 'Complications', 'Induction of labour for Big Baby', Dr Lum said: I

This lady was almost at term and if it was felt that the baby was big and the likelihood of that baby being bigger than the first one, certainly one would have

A considered induction. *But certainly one would have had to consider and offer the lady an option of a caesarean section particularly when that information of the first baby being 4.54kg was documented and the likelihood of a subsequent baby being heavier than that*. As I referred to in the paper that I attached from the University of Malaya, they took the definition of a 'big baby' as greater than 3.5 kg. (Emphasis added.)

B

[64] When asked whether he saw from the records, any offer of caesarean section without undertaking induction of labour replied that from D1's note 'Induction as cervix still unfavourable, needs overnight prostin, then syntocinon, if fails, for LCSC, not keen' Dr Lum replied that he presumes that C there might have been some discussion about caesarean section or certainly the patient should have been informed. He had also concluded in para 4.47 of his expert opinion, based on D1's notes that 'There was documentation that Dr PD (Dr Premitha) discussed induction and caesarean section, should it fail with BKG (Mdm Baljeet)'.

D

[65] However, as Dr Lum had given his evidence during the trial before D1, he did not have the opportunity to hear D1's oral testimony that contrary to what was stated in her medical notes or pleaded in her amended defence, D1 admitted that she did not in fact discuss or offer Mdm Baljeet the option of a E caesarean section during the ante-natal consultations or during the process of delivery.

[66] Dr Murali had concluded in his expert report that Dr Premitha had discussed the delivery options with Mdm Baljeet prior to the induction of her F labour (pp 47 and 53 of the *Ikatan Laporan-Laporan Pakar* (ER)). However, during cross-examination, Dr Murali accepted that the medical records do not show any discussion regarding delivery options save for the discussion on induction. He also agreed that D1 should have discussed the delivery options including a lower segment caesarean section (LSCS) with Mdm Baljeet before G Mdm Baljeet decided on delivery options. Excerpts of the relevant questions and answers relating to delivery options during Dr Murali's cross-examination are reproduced below:

Plaintiffs' counsel: There is no record regarding delivery options, right Doctor?

H Dr Murali: Yes

...

Plaintiffs' counsel: And it appears that what was discussed was that induction to be undertaken and the timing of the induction?

I Dr Murali: Yes

...

Plaintiffs' counsel: And the patient was told if induction fails, then we have to consider lower segment caesarean section?

Dr Murali: Yes

Plaintiffs' counsel: There was no discussion about the delivery options because the focus was on undertaking induction, right Doctor?

Dr Murali: Yes. On page 26, at the end there, it is written that 'Keen on induction', I'm not sure whether there was a discussion on delivery options there.

Plaintiffs' counsel: But it's not mentioned there?

Dr Murali: Yes, it's not mentioned ...

Plaintiffs' counsel: Doctor, then I go to page 53 of your report, the last paragraph, 'The documents indicate that Dr Premitha discussed delivery options'. Doctor, we have gone through, she discussed induction?

Dr Murali: Yes

Plaintiffs' counsel: So delivery options were not discussed, page 28?

Dr Murali: Yes ...

[67] Dr Murali agreed with Mr MS Dhillon's suggestion during cross-examination that 'irrespective of the dispute now about the weight of the first baby, if during this pregnancy, Dr Premitha describes it as a big baby, she should have concerns regarding passage and passenger'.

[68] The evidence shows that during the ante-natal visits, D1 did not inform Mdm Baljeet of the option of delivery by way of caesarean section. As D1 herself admitted under cross-examination, she did not inform Mdm Baljeet of the option of a caesarean and her claim that she did so in the amended defence was in fact untrue.

[69] The evidence also shows that D1 did not offer to Mdm Baljeet the option of delivering Gurisha by caesarean section during labour, when there was difficulty in delivering Gurisha's shoulders. Under cross-examination, D1 confirmed that she did not offer Mdm Baljeet the option of delivery by caesarean section during labour. D1 said 'I did not offer a caesarean section'. When asked why she did not offer Mdm Baljeet a caesarean section during delivery, D1 replied 'There was no need for a c-section because the head was just sitting there ...'.

[70] In para 23C of her amended defence, D1 pleads that Mdm Baljeet had consented to the risks of per vaginum delivery of baby Gurisha:

> 23C. The 1st Defendant will also state that the Mother on her own volition consented to the risk of per vaginum delivery of the Baby despite knowing and/or reasonably ought to have known the correct birth weight of her first child and therefore voluntarily ran the risk and/or fully agreed to the risk and/or knew the extent of the risk of her delivery.

[71] This court is unable to agree with D1's assertion that Mdm Baljeet had consented to the risks of a vaginal delivery. How could Mdm Baljeet have consented to the risks of a vaginal delivery when D1 did not discuss with her the risks and benefits of such vaginal delivery or discuss with her the option of delivering the baby by way of a caesarean section and its risks and benefits? As the High Court of Australia held in *Rogers v Whitaker*, 'the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended'. In this case, as D1 herself testified, she did not discuss with Mdm Baljeet on the option of a caesarean section. Additionally, the facts show that she did not inform Mdm Baljeet of the risks and benefit of delivery by induction. D1's medical notes show that she advised Mdm Baljeet of delivery by induction because Mdm Baljeet was keen not to go past her due date and that Dr Premitha was going away for a conference from 16–19 May 2014.

[72] In para 23D of her amended defence, D1 pleads:

> 23D. The 1st Defendant states that had the 1st Defendant been correctly informed that the Mother's 1st baby weighed considerably less than 4.54kg, the 1st Defendant would not have allowed the Mother to proceed with a vaginal delivery and instead insisted on a C-section delivery.

[73] With respect to D1, it is not a question of the doctor not allowing a patient to proceed with vaginal delivery and insisting that she delivers by way of a caesarean section. It is settled law that D1 as a doctor has a duty of care to her patient to advise the patient of the available options of treatment and the corresponding risks and benefits of such options, so as to enable the patient to make an informed decision in giving her consent for the treatment.

[74] Both Dr Lum and Dr Murali are in agreement that Mdm Baljeet as a patient should have been given the various delivery options and its risks and benefits so as to enable her to make an informed decision. In this case, D1 neither gave Mdm Baljeet the available delivery options nor did she discuss with Mdm Baljeet the risks and benefits of the options.

[75] D1 did not give Mdm Baljeet, the necessary information so as to enable her to make an informed decision. Her pleaded defence — her first line of defence — is she did give the option of a caesarean section, which she herself during the trial admitted was untrue. Her unpleaded defence — her second line of defence — is that she did not discuss the option of a caesarean section because the diagnosis and treatment she rendered was based entirely on the history given by the Mdm Baljeet of the birthweight of her elder son Soheil who was delivered by way of vaginal delivery 11 years earlier.

[76] Learned counsel for D1, Ms Sharon Palani submits that Mdm Baljeet

had misled D1 of Soheil's birthweight, which led to her being unable to assess the true condition of Gurisha's weight in correlation with Mdm Baljeet's ability to deliver. Learned counsel said that no reasonable doctor will doubt a Cambridge educated mother, who at the material time was the Managing Director of Strategy and Portfolio Investment of Samruk Kazyna, the Sovereign Wealth Fund of Kazakhstan.

[77] I have to respectfully disagree with Ms Palani. I find that it is irrelevant that Mdm Baljeet graduated from Cambridge University with a First Class Honours in Economics. She was not educated in medicine or obstetrics. D1 as her attending obstetrician should have informed her that providing an accurate birthweight of her older son is important for D1 to advise her of the appropriate delivery options.

[78] The law regarding advice and information was recently reviewed and restated by the UK's Supreme Court in *Montgomery v Lanarkshire Health Board (General Medical Council intervening)* [2015] UKSC 11; [2015] AC 1430; [2015] 2 WLR 768. In that case, Mrs Montgomery sought damages on behalf of her son who had suffered severe and continuing injuries as a result of shoulder dystocia at the time of his birth. The UK Supreme Court held that a doctor had a duty to take reasonable care to ensure that the patient was informed about any material risks involved in the recommended treatment, and any reasonable alternative treatments. The test of materiality was whether, in the circumstances, a reasonable person in the same position as the patient would be likely to regard a particular risk as significant, or the doctor was or should reasonably be aware that the patient would be likely to attach significance to it, and was impossible to reduce to percentage terms the assessment of materiality of risks. 'Therapeutic exception' was a limited exception to the general principle and it did not allow doctors to prevent their patients from taking an informed decision. It was the doctor's responsibility to explain in comprehensible terms to the patient why one of the available treatment options was medically preferable to the others, after taking care to ensure that the patient was aware of the considerations for and against each of them.

(b) Did D1 inform Mdm Baljeet of risk of shoulder dystocia?

[79] Dr Lum concluded in para 4.48 of his expert opinion that based on the available documentation D1 did not provide Mdm Baljeet with any information about her risk factors, namely, foetal macrosomia and maternal obesity, the consequences of foetal macrosomia or various aspects of its management including alternative delivery by caesarean section.

[80] Dr Lum referred to a study from University Hospital, Kuala Lumpur by

Asmah Mansor et al entitled *Macrosomia is the only reliable predictor of shoulder dystocia in babies weighing 3.5kg or more*, published by the European Journal of Obstetrics & Gynaecology and Reproductive Biology 149 (2010) 44–46 ('the UH Study'). The UH Study defined macrosomia as foetal weight of 3.5kg or more. It found that:

> Although diabetes and instrumental delivery were independently and significantly associated with shoulder dystocia their importance as a predictor became relevant only in the presences of macrosomia.

The UH Study concluded that 'macrosomia is the only reliable predictor of shoulder dystocia'.

[81] D1 did not inform Mdm Baljeet of the risk that her second child would be macrosomic. She also did not advise Mdm Baljeet that there is a risk of shoulder dystocia during the vaginal delivery of a macrosomic baby. She failed to advise Mdm Baljeet that the baby in utero was at higher risk of becoming macrosomic (larger than average baby) based on the Mdm Baljeet's first child Soheil and her maternal obesity. D1 also failed to advise Mdm Baljeet of the high risk of shoulder dystocia in macrosomic babies. When D1 saw Mdm Baljeet on 12 May 2014, she noted in her medical records that the estimated foetal weight of the baby was 3.8–4kg. And on 13 May 2014, when Mdm Baljeet was admitted into Pantai Hospital KL for induction of labour, D1 documented 'big baby' at 40 weeks.

[82] The UH Study clearly conclude that there is a high risk of macrosomic babies weighing 3.5kg or more developing shoulder dystocia. Dr Lum expressed the opinion that as Mdm Baljeet's first baby was big, D1 should have informed Mdm Baljeet of the likelihood that her second baby will be bigger and should have offered her the option of a caesarean section. Dr Lum's opinion is reproduced below:

> In this case, the first baby is big and I think the mother has to be informed that the likelihood of the second baby being bigger than the first is there and that there is a possibility of complication and then a caesarean section has to be offered as an option.

[83] Dr Lum said that although a caesarean section does not always prevent shoulder dystocia as there are studies which support that it does and there are studies which support that it doesn't, 'but certainly, the patient has to be given this information so that she can make an informed decision'.

[84] Dr Murali agreed that if a doctor lacked sufficient experience in dealing with a shoulder dystocia case during delivery, then the doctor should disclose the information to the patient so as to allow the patient to exercise her choice.

[85] The law is very clear. A doctor has the duty to advise and provide the necessary information to his patient to enable the patient to make an informed decision as to his treatment. In a pregnancy, the doctor has the duty to advise the mother as to what are her delivery options and to provide her with the necessary information to enable her to make an informed choice.

[86] Lady Hale in *Montgomery v Lanarkshire Health Board (General Medical Council intervening)* held that in a pregnancy, the doctor must give sufficient information to enable the mother to make the choices and to consider arguments for and against each delivery option and that 'the principal choice is between vaginal delivery and caesarean section'. Her Ladyship held:

> (108) *It is now well recognised that the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body* (the unwanted pregnancy cases are an example: see *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52 ; [2004] 1 AC 309). Thus, as Jonathan Herring puts it in Medical Law and Ethics (2012), 4th ed, p 170), *'the issue is not whether enough information was given to ensure consent to the procedure, but whether there was enough information given so that the doctor was not acting negligently and giving due protection to the patient's right of autonomy'.*
>
> (109) An important consequence of this is that it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done: see the approach of the General Medical Council in Consent: patients and doctors making decisions together (2008), para 5, quoted by Lord Kerr and Lord Reed at para 77 and approved by them at paras 83 to 85.
>
> (110) *Pregnancy is a particularly powerful illustration. Once a woman is pregnant, the foetus has somehow to be delivered. Leaving it inside her is not an option. The principal choice is between vaginal delivery and caesarean section.* One is, of course, the normal and 'natural' way of giving birth; the other used to be a way of saving the baby's life at the expense of the mother's. Now, the risks to both mother and child from a caesarean section are so low that the National Institute for Health and Clinical Excellence (NICE clinical guideline 132, [new 2011] [para 1.2.9.5]) clearly states that 'For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS. (Emphasis added.)

[87] Therefore, based on the applicable law, whether or not Mdm Baljeet gave D1 the correct birthweight for her older son, it does not remove D1's duty as a doctor to advise her patient, Mdm Baljeet, of the available delivery options and the pros and cons of each option so as to enable Mdm Baljeet to make an informed choice. The evidence shows that D1 did not discuss with Mdm Baljeet the option of delivery of caesarean section and the risk of shoulder

dystocia; nor did she discuss the pros and cons of vaginal delivery and delivery by way of a caesarean section. Although, D1 noted that the baby in utero was a 'big baby' and that the baby's estimated foetal weight was 3.8–4kg, she failed to advise Mdm Baljeet that there is a high risk that the baby will be macrosomic. She also failed to advise Mdm Baljeet that there is a risk of shoulder dystocia during the vaginal delivery of a macrosomic baby. As the UH Study concluded, macrosomia is a predictor of shoulder dystocia in babies weighing 3.5kg or more.

[88] D1 only noted in her medical records that Mdm Baljeet was not keen to have a caesarean section. As Dr Lum testified, mothers are usually not keen to have a caesarean section. Just because a mother says that she is not keen to have caesarean section, does not mean that the doctor is absolved from her duty to inform the mother of the available options and the risks associated with vaginal delivery and the risk that the baby is likely to be macrosomic and that shoulder dystocia is likely to occur during delivery of such macrosomic baby. It also does not absolve the doctor from informing the mother that the doctor has limited experience in handling shoulder dystocia emergencies.

[89] It is evident from the available facts that D1 did not provide Mdm Baljeet any information of the risks associated with an induced vaginal delivery. The clinical notes show that induction was decided because D1 was going away and Mdm Baljeet was not keen to go beyond her due date.

[90] Additionally, D1 did not during the any of the ante-natal consultations inform Mdm Baljeet of her limited experience in dealing with emergencies relating to shoulder dystocia. In fact, there is nothing in D1's medical notes to show that the risk of shoulder dystocia or D1's experience or lack thereof in managing shoulder dystocia emergencies during delivery was discussed with Mdm Baljeet.

[91] Mdm Baljeet testified that if she was informed of D1's limited experience in dealing with shoulder dystocia complications, she would have looked for another obstetrician and gynaecologist as she was concerned with the safety of her unborn child, who was conceived through IVF and was a precious baby.

[92] Having regard to the evidence, and as D1 herself submits, Mdm Baljeet is a well-educated lady who graduated with a first class degree in economics from Cambridge University, the only conclusion that I can reasonably reach is that, had D1 advised Mdm Baljeet of the risk of shoulder dystocia and discussed with her the potential consequences (including injury to the baby), and the option of an elective caesarean section, Mdm Baljeet would have likely elected for her baby to be delivered by caesarean section. Also, if D1 had told

Mdm Baljeet that she had limited experience in dealing in shoulder dystocia cases, Mdm Baljeet would have likely, as she had testified in court, sought the services of another obstetrics and gynaecologist, particularly since Gurisha was a 'precious baby' conceived by IVF ten years after her first pregnancy and earlier failed IVF.

[93] For these reasons, I find the following:

(a) that D1 had a duty to advise Mdm Baljeet of the available delivery options, namely vaginal delivery and caesarean section;

(b) that D1 had a duty to discuss and advise Mdm Baljeet of the risks associated with each delivery option;

(c) that D1 had a duty to inform Mdm Baljeet that because her first baby was macrosomic, it is likely that the second baby will be macrosomic too and that there is a risk of shoulder dystocia in the vaginal deliveries of macrosomic babies;

(d) that D1 had a duty to inform Mdm Baljeet that she had limited experience of managing shoulder dystocia complications during delivery; and

(e) that D1 failed to provide Mdm Baljeet with the aforementioned information and advice so as to enable Mdm Baljeet to make an informed decision as to her choice of delivery.

[94] Accordingly, I find that D1 had failed to discharge her duty to advice and inform Mdm Baljeet according to applicable the standard of care.

(c) Did D1 undertake correct management of shoulder dystocia during labour and delivery?

[95] The book *Clinical Protocols in Obstetrics and Gynaecology for Malaysian Hospitals: A must have compendium for Practitioners of Obstetrics & Gynaecology*, (Editors: Prof Dato' Dr Sivalingam Nalliah ND Prof Dato' Dr Sachchithanantham Kanagasabai) ('O&G Clinical Protocols Compendium') describes the common features of shoulder dystocia as 'there is an arrest of spontaneous delivery due to impaction of the anterior shoulder against the symphysis pubis'. It states that degree of difficulty varies from being 'slight' to 'severe'. In the latter both shoulders are 'stuck' above the symphysis.

[96] D1 in her clinical progress notes wrote 'Ant. shoulder could not be brought forward'. But in her medical report and witness statement, D1 stated that Gurisha's both shoulders were stuck after her head had come out. Under cross-examination, D1 said that she had never faced a situation similar to

Gurisha's birth, where the baby did not face the thigh of the mother after her head came out but was looking down. She said 'I have never faced a similar position; I hope never to face it again'.

[97] Dr Murali said that he had never seen a case of both being shoulders being stuck and opined that if both shoulders were stuck then the vaginal canal was not adequate for the delivery. He concluded that when shoulder dystocia was noted after delivery of the baby's head, 'various procedures had to be performed before the shoulder and the rest of the body could be delivered' (p 50 of the *Ikatan Laporan-Laporan Pakar* (ER)); and that 'subsequent delivery required further manipulation' (p 54 of the *Ikatan Laporan-Laporan Pakar* (ER)).

[98] Notwithstanding the complications in delivering baby Gurisha's shoulders during labour because of the shoulder dystocia, the evidence shows that D1 also did not offer to Mdm Baljeet the option of delivering Gurisha by caesarean section during labour. D1 confirmed that she did not offer Mdm Baljeet the option of delivery by caesarean section during labour. She said under cross-examination, 'I did not offer a caesarean section'.

[99] Both Dr Lum and Dr Murali, testified that in the case of shoulder dystocia during childbirth, the McRoberts manoeuver should be employed to try to deliver the baby. If the baby is still not delivered, suprapubic pressure should then be applied when the mother is in the McRoberts position to try to free the shoulder. The McRoberts manoeuver involves flexing the mother's knees and thighs toward her shoulders, while she is lying on her back.

[100] The *O&G Clinical Protocols Compendium* at p 420 states:

> It is mandatory that the McRoberts position be achieved as soon as SD [shoulder dystocia] is diagnosed. Suprapubic pressure assists to adduct and internally rotate the anterior shoulder so as to reduce the bis-acromial diameter. The heel of the hand is used to execute this manoeuvre. Ensure the side the fetal lies is determined so as to apply the pressure in the right direction.
>
> • *Only after these TWO steps (ie Mc Roberts and suprapubic pressure) are in place should gentle traction be given in an attempt to deliver the baby*. (Emphasis added.)

[101] D1 claims that the nurses had undertaken the McRobert's manoeuver before she undertook manipulation to deliver baby Gurisha. However, the evidence shows that D1 failed to undertake the McRoberts manoeuver correctly. She had pulled out Gurisha's shoulders before the nurses could undertake the McRoberts manoeuver.

[102] Nurse Ng Soo Ling (SD5) who had assisted D1 in the delivery testified that even before she could complete the Mc Roberts manoeuver, D1 had 'managed to pull the baby out'. Excerpts of Nurse Ng's testimony relating to the McRobert's manoeuver are reproduced below:

> Plaintiffs' counsel: Who's the other nurse?
>
> Nurse Ng: Vanitha. Get the things ready for her to do the forceps. So when everything is ready, the patient is ready, she applied the forceps and its was done without difficulty, the head came out nicely. But after that when she take out the forceps and everything, the head didn't turn. Normally, after the delivery, the head will turn automatically and then the anterior shoulder would come out and the cord was quite tightly around the neck. *So she tell us to prepare for the McRoberts manoeuvre. So we just put the patient down and put the legs up. Before we can do that, she already managed to deliver the shoulder.*
>
> ...
>
> Nurse Ng: *Dr Premitha was trying to see whether she can deliver the shoulder at the same time. So that's why when we do all these procedure, just about to get her to push with the Mc Roberts manoeuvre, the baby already came out.*
>
> Plaintiffs' counsel: So when you say 'just about to', why you say the baby already came out?
>
> Nurse Ng: What I mean is, *when we have the patient ready to do the Mc Roberts, we still have to have the patient to push. Before we can do that, Dr Premitha already managed to pull the baby out*. (Emphasis added.)

[103] Dr Lum concluded that Gurisha's brachial plexus injury was likely to have been caused by excess traction. He stated as follows, at para 6.4.c at p 20 of his expert's report, as regards the management of the shoulder dystocia during Mdm Baljeet's labour:

> c. The management of the SD [shoulder dystocia], which resulted in GK's BPI [Gurisha Kaur's brachial plexus injury], was substandard because:
>
> (i) There was no documentation that the signs of the SD (Paragraph 5.5h) were promptly recognised.
>
> (ii) Dr PD [Dr Premitha Damodaran] failed in her attempt at McRoberts manoeuvre (Paragraph 4.25). Although it is unclear whether suprapubic pressure was applied (Paragraph 5.5p), it would have been difficult for one of the two nurses present (Paragraph 4.26) to assist in the McRoberts manoeuvre and apply suprapubic pressure concomitantly. As there are fewer attendants than necessary, it is likely the McRoberts manoeuvre could not be executed properly.
>
> (iii) It is likely that GK's BPI [Gurisha Kaur's brachial plexus injury], was caused by excess traction (Paragraph 5.6c–5.6e)

[104] I find that from Nurse Ng's testimony, it is clear that the D1 had 'pulled the baby out' before the McRoberts manoeuvre was completed and the suprapubic pressure was applied. Mdm Baljeet testified that excessive force was used when D1 had used the forceps to deliver Gurisha. When D1's counsel suggested to Mdm Baljeet during cross-examination that D1 delivered baby Gurisha with one pull, Mdm Baljeet replied:

> That is wrong, it was not one pull. She yanked the forceps into my vagina with such force my butt moved off the table and then she proceeded to yank me with her entire body force. And then once she had done that about 2 or 3 times, she tugged it one, twice and then the baby's head came out. So exactly what do you mean by one pull because that was not what occurred in the delivery room, my baby was badly damaged. This is flawed and fabricated.

[105] The *O&G Clinical Protocols Compendium* in p 418, in a table headed 'Emergency steps in Management of Shoulder Dystocia' starts with:

> Call for HELP, senior staff must be called in
>
> • Inform mother to stop pushing

and on p 419 states:

> • Breathe: Mum is not to push, lower head of bed and ask mum to breathe normally (or pant)
>
> • Elevate Legs: McRobert's position
>
> • Call for help (other personnel — paediatrician, anaesthesiologist)
>
> • Apply suprapubic pressure
>
> • Enlarge the vaginal opening: Episiotomy
>
> • Manoeuvres

[106] However, in this case, Nurse Ng had testified that when the shoulder dystocia was identified, Mdm Baljeet was going to be asked to push. Nurse Ng said 'when we have the patient ready to do the Mc Roberts, we still have to have the patient to push'. This is clearly contrary to clinical protocols for managing shoulder dystocia as set out in the O&G Clinical Protocols Compendium.

[107] Under cross-examination by the plaintiffs' counsel, Dr Murali had agreed that once shoulder dystocia has occurred, the mother should not be encouraged to push because it will increase the risk of brachial plexus injury. He had also testified that in cases of shoulder dystocia, the McRoberts manoeuver should be employed to try to deliver the baby. If the baby is still not delivered, suprapubic pressure should then be applied when the mother is in the McRoberts position to try to free the shoulder. This is consistent with the

guidance written in the O&G Clinical Protocols Compendium, of which Dr Murali is one of the contributing authors. A

[108] However, during re-examination, when asked by D1's counsel, Dr Murali changed his testimony. He said that if he looked at Nurse Ng's evidence in isolation there was no mismanagement of the shoulder dystocia during labour. He tried to explain away his earlier testimony during cross-examination where he had agreed that when the baby's shoulder is stuck, the mother should not be told to push, by saying in re-examination (which took place after an adjournment of proceedings) that 'when I answered this question, I looked at the whole series of questions that were asked prior to this and there we speak about a shoulder being impacted'. He then went to say that 'But if I read this (Nurse Ng's testimony that the mother is to be asked to push) in isolation, there does not appear to be any mismanagement'. When asked by D1's counsel what in his view caused Gurisha's shoulder injury, Dr Murali, in complete contrast to his answer during cross-examination made an about turn and answered 'the amount of manipulation carried out would not have been extensive. In the absence of excessive manipulation, I would assume that the most likely cause would be maternal propulsion'. B C D E

[109] I find that Dr Murali's change of opinion during re-examination by D1's counsel does not withstand logical analysis. His opinion ignores the fact that D1 had failed to follow established medical protocols in managing cases of shoulder dystocia as set out in the *O&G Clinical Protocols Compendium*. I find this particularly puzzling since Dr Murali is one of the contributing authors of the Compendium. Also, his testimony during re-examination by D1's counsel that the most likely cause of Gurisha's brachial plexus injury is caused by maternal propulsion differs from his testimony during cross-examination and also departs from his own expert report. F G

[110] Following the decision of the Federal Court decision in *Zulhasnimar bt Hasan Basri* and the House of Lords in *Bolitho*, since this court finds that Dr Murali's medical opinion does not withstand logical analysis, this court holds that his opinion is not reasonable or responsible and accordingly departs from it. H

[111] For the reasons stated above, I cannot accept Dr Murali's opinion expressed during re-examination that D1's manipulation of the baby during delivery was not excessive and that D1 did not mismanage the shoulder dystocia during delivery. His opinion does not withstand logical analysis — it is not backed by evidence and goes against established medical protocols on the management of shoulder dystocia. Additionally, I am unable to accept D1's submission and Dr Murali's opinion that the brachial plexus injury to Gurisha's left shoulder was caused by maternal propulsions. I

[112] It is trite law that a party is bound by her pleadings. D1 did not plead in her defence that maternal propulsions had caused the brachial plexus injury to Gurisha. She cannot, therefore, during trial and in her submissions, raise an allegation that was not pleaded, namely that maternal propulsions had caused Gurisha to suffer brachial plexus injury.

[113] The Court of Appeal in *The Carbon Co Sdn Bhd & Anor v Ng Lee Hoon (conducting under 'Forest Wood Flooring')* [2017] 4 MLJ 791; [2017] 6 CLJ 189 reiterated the settled principle that parties are bound by their pleadings:

> [36] Pleadings play an important role in civil litigation, as parties are bound by their respective pleadings. This is trite. The facts pleaded in the pleadings will define the parameters of each party's case and serve as a clear notice to the adverse party the case that will be adjudicated so as to prevent either party from being taken by surprise during trial. Pleadings too will serve a guide to the court in determining the issues to be tried.

[114] Furthermore, it is a settled principle of litigation that it is not the function of the court to build a case for the litigants, inconsistent with their pleadings. The Supreme Court in *Yew Wan Leong v Lai Kok Chye* [1990] 2 MLJ 152; [1990] 1 CLJ 1113; [1990] 1 CLJ Rep 330 explained the principle as follows:

> In disposing of a suit or matter involving a disputed question of fact, it is not proper for the court to displace the case made by a party in its pleadings and give effect to an entirely new case which the party had not made out in its own pleadings. The trial of a suit should be confined to pleas on which the parties are at variance.

[115] In my view, D1's failure to undertake the McRoberts maneuver correctly and apply the suprapubic pressure before applying traction to deliver the baby, constitutes a breach of her duty of care. As Nurse Ng testified, D1 had 'pulled out the baby' before the McRoberts manoeuvre could be undertaken. Nurse Ng's testimony shows that the McRoberts manoeuvre was not undertaken although D1 had written in her clinical progress notes that 'McRoberts done by nurses immediately'. The evidence shows that D1 did not apply suprapubic pressure or enlarge the vaginal opening through an episiotomy, before pulling the baby out.

[116] I find that based on the available evidence, the plaintiffs have proven on a balance of probabilities that the brachial plexus injury to baby Gurisha's shoulder was caused by D1's mismanagement of the shoulder dystocia, by her failure to follow established clinical protocols in dealing with cases of shoulder dystocia and by the manoeuvre she had used in pulling the baby out. I accept Dr Milton Lum's evidence that in his expert opinion that it can be inferred

from the medical records that excessive traction was applied by D1 during the delivery. I find his opinion to reasonable, responsible, respectable and stands up to logical analysis.

[117] For these reasons, I conclude that D1 had breached her duty of care in managing the shoulder dystocia during the delivery and that she had failed to apply the requisite standard of care in delivering baby Gurisha and that her breach of her duty of care had caused Gurisha to suffer brachial plexus injury to her left shoulder.

[118] This court concludes that but for D1's failure to advise and provide Mdm Baljeet with the delivery options and the information necessary for her to make an informed choice and D1's failure to comply with established medical protocols and the applicable standard of care in shoulder dystocia cases during delivery, Gurisha would not have suffered brachial plexus injury to her left shoulder and Mdm Baljeet would not have suffered the injury to her perineum.

(d) Was Mdm Baljeet contributorily negligent?

[119] As discussed above, in her second line of defence, D1 says that she did not give Mdm Baljeet any information on delivery by way of caesarean section because based on Soheil's birth weight, Mdm Baljeet should be able to deliver a larger baby through vaginal delivery. In para 23B of her amended defence, D1 pleads that Mdm Baljeet by not giving D1 an accurate birth history, failed in her responsibility to disclose her true history and is contributorily negligent and any damages must be apportioned accordingly.

[120] D1 has not proven to this court beyond reasonable doubt that Mdm Baljeet and her husband had indeed told her that Soheil's birthweight was 4.54kg. Both Mdm Baljeet and her husband deny having informed D1 that Soheil's birthweight was 4.54kg. They both state in their respective witness statements state that Soheil's birth weight was approximately 4kg.

[121] The issue before this court is even if D1 successfully discharged the burden of proving that Mdm Baljeet and her husband had informed her that Soheil's birthweight was 4.54kg, was Mdm Baljeet contributorily negligent for the injuries that she and Gurisha suffered as a result of D1's negligence?

[122] What is contributory negligence and what is the test to determine whether there was contributory negligence? *Clerk & Lindsell on Torts* (12th Ed, Sweet & Maxwell), referring to *Ellerman Lines Ltd v H & C Grayson Ltd* [1919] 2 KB 514 at p 535; and *Grayson (H & C) v Ellerman Line Ltd* [1920] AC 466 at p 477; *Lewis v Denye* [1939] 1 All ER 310; [1939] 1 KB 540 at p 544; *Davies v Swan Motor Co (Swansea) Ltd* [1949] 2 KB 291 at p 309; *Jones v Livox*

Quarries Ltd [1952] 2 QB 608 at p 615 states that:

> Contributory negligence does not mean that claimant commits a breach of duty towards the defendant, ... it means that the claimant failed to use reasonable care for his own safety and so contributed to his own damage.

[123] The Federal Court in *Ong Ah Long v Dr S Underwood* [1983] 2 MLJ 324; [1983] 2 CLJ 198; [1983] CLJ Rep 300 held that the learned High Court judge had applied the correct test in determining whether there was contributory negligence. Syed Agil Barakbah FJ at p 327 (MLJ) held:

> The learned judge applied the correct test in that the appellant had failed to prove that *the respondent did not on his own interest take reasonable care of himself and contributed by that want of care to his own injury*. (*Lewis v Denye* [1939] 1 All ER 310). *The test for contributory negligence in the case of a pedestrian is not whether he is under a duty of care towards the defendant, but whether he was acting as a reasonable man and with reasonable care.* (Per Denning LJ in *Davies v Swan Motor Co* [1949] 1 All ER 620.) (Emphasis added.)

[124] In *Ong Ah Long*, the Federal Court referred to an English Court of Appeal case of *Lewis v Denye* [1939] 1 All ER 310; [1939] 1 KB 540, where the court held:

> In order to establish the defence of contributory negligence, the defendant must prove (i) *that the Plaintiff failed to take 'ordinary care for himself,' or, in other words, such care as a reasonable man would take for his own safety,* and (ii) *that his failure to take care was a contributory cause of the accident*. *The doctrine of contributory negligence 'cannot be based upon a breach of duty to the negligent defendant'*: *Craze v Meyer-Dumore Bottlers' Equipment Co Ltd*, *Salmond on Torts*, 9th Edn, at pp 472, 473, and *Grayson (H & C) v Ellerman Line Ltd*, per Atkin LJ, at pp 535, 536. (Emphasis added.)

[125] In *Jones v Livox Quarries Ltd* [1952] 2 QB 608, Lord Denning said the following as regards contributory negligence:

> *Although contributory negligence does not depend on a duty of care, it does depend on foreseeability*. Just as actionable negligence requires the foreseeability of harm to others, *so contributory negligence requires the foreseeability of harm to oneself*. A person is guilty of contributory negligence if he ought reasonably to have foreseen that, if he did not act as a reasonable, prudent man, he might be hurt himself; and in his reckonings he must take into account the possibility of others being careless.
>
> Once negligence is proved, then no matter whether it is actionable negligence or contributory negligence, the person who is guilty of it must bear his proper share of responsibility for the consequences. *The consequences do not depend on foreseeability, but on causation. The question in every case is: What faults were there which caused the damage? Was his fault one of them?* (Emphasis added.)

[126] The test in *Jones v Livox Quarries Ltd*, was adopted by Lamin Yunos J (as he then was) in *Ruhani bte Mohiat & Anor v Abdul Karim bin Mat Ali & Anor* [1993] MLJU 563; [1993] 2 AMR 1339.

[127] It is clear from these aforementioned cases that contributory negligence is not based on the claimant's duty of care to the negligent defendant. It is dependent on whether the claimant ought to have reasonably foreseen the harm to himself if he failed to take reasonable care of himself. A person is contributory negligent for the harm caused to himself if he ought reasonably to have foreseen the injury and he did not take reasonable care of himself.

[128] Applying these established legal principles to this present case, whether or not Mdm Baljeet is contributory negligent is not dependent on any duty of care she owed to D1. It is not a question of whether she 'failed in her responsibility to disclose her true history and is contributory negligent' as pleaded by D1 in para 23B of her amended defence. Mdm Baljeet would only be contributory negligent for the harm caused by D1 to herself and Gurisha if she ought reasonably to have foreseen the injuries and she did not take reasonable care of herself.

[129] D1 and Mdm Baljeet are in a doctor-patient relationship. As a doctor, D1 has a duty of care to diagnose, advice and treat Mdm Baljeet: see the Federal Court decisions in *Foo Fio Na v Dr Soo Fook Mun & Anor* and *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors*. Therefore, D1 owes Mdm Baljeet a duty of care to advise her and provide her information of the available delivery options of vaginal delivery and caesarean section and to inform her of the risk and benefits of both options, so as to enable her make to make an informed decision.

[130] Whether or not Mdm Baljeet provides D1 Soheil's accurate birthweight does not negate D1's duty to advise her of the available delivery options and to provide the necessary information in order for her to make an informed choice of the delivery option and to give her informed consent. The UH Study shows that babies who are 3.5kg or more are macrosomic and that the risk of shoulder dystocia during the delivery of macrosomic babies are higher. Also, as Dr Milton Lum testified babies generally are larger as the birth order increases. These are facts which are known to D1 as a consultant obstetrician and gynaecologist but not to Mdm Baljeet, who as the patient is owed a duty of care by D1 to advise her and provide her with all this information.

[131] As a patient, without being informed by D1 of the delivery options, the risk of the baby she is carrying will be macrosomic and the risk of shoulder dystocia in the vaginal birth of a macrosomic baby, Mdm Baljeet would not be

able to foresee the harm to herself and to her unborn baby if she does not provide D1 with Soheil's accurate birthweight.

[132] From the available evidence before this court, I find that D1 had failed to prove on a balance of probabilities that Mdm Baljeet and her husband had informed D1 that Soheil's birthweight was 4.54kg. D1's contention is based on her own record of the first consultation she had with Mdm Baljeet. Both Mdm Baljeet and her husband had denied that they told D1 that Soheil's birthweight was 4.54kg. Also, in their respective witness statements they had stated that Soheil's birthweight was 'approximately 4kg'.

[133] Furthermore, based on the doctor-patient relationship between D1 and Mdm Baljeet, I find that D1 had failed to prove the first limb of the test for contributory negligence, namely that Mdm Baljeet ought to have reasonably foreseen the harm to herself and to her baby if she gave D1 an inaccurate birthweight for her son who was born ten years earlier. The damage is too remote — how can Mdm Baljeet reasonably foresee that if she did not give D1, Soheil's accurate birthweight, D1 would breach her duty of care as a doctor and not advise her of caesarean section as a delivery option and the high risk of shoulder dystocia in the vaginal delivery of a macrosomic baby?

[134] I also find that D1 failed to prove the second limb of the test for contributory negligence. She failed to prove that Mdm Baljeet failed to take ordinary care of herself as an ordinary person would in the circumstances.

[135] For these reasons, I find that Mdm Baljeet was not contributorily negligent for the damages caused to her and Gurisha by D1's negligence.

(e) Were Mdm Baljeet's injuries sufficiently identified, treated and managed?

[136] It is not in dispute that Mdm Baljeet suffered injuries to her vagina and perineum as a result of the delivery of baby Gurisha. What is in dispute is the extent of the injury and whether the injuries had been sufficiently identified, treated and managed.

[137] D1 noted that Mdm Baljeet's injuries to her perineum was 'only small fourchette tear' and 'only small vaginal tear, which was sutured in 2 layers'. However, the nurses in their notes described Mdm Baljeet's injury as 'second degree tear' of the perineum.

[138] Dr Milton Lum says that there is a marked difference between D1's finding that there is 'a small fourchette tear' and the second-degree tear found by the nurses and Dr Hu Shan. Dr Lum is of the opinion that 'the nurses' documentation and Dr HS' finding were more plausible'. He also opined in

para 6.1(j) of his expert opinion that it is likely that D1 failed to diagnose the second-degree perineal laceration because D1 did not conduct a thorough pelvic examination before and after suturing the laceration, which was not in accordance with accepted practice. Dr Lum stated in para 5.7(c) of his expert opinion that:

> Instrumental deliveries, whether forceps or vacuum extractions are associated with increased risk of perineal lacerations. As such, digital vaginal and rectal examination is traditionally recommended after repair to ensure it has been completed satisfactorily.

[139] Dr Lum concluded that had D1 carried out a thorough pelvic examination, Mdm Baljeet's second degree perineal laceration would have been diagnosed and sutured appropriately; thus sparing her the pain and suffering until she consulted Dr Hu Shan.

[140] Dr Murali stated in his expert opinion that a tear to the perineum are common after the delivery. However, he did not offer an opinion on the difference in findings by D1, the nurses and Dr Hu Shan of the extent of the injury and the need to properly diagnose the extent of the tear to ensure that it is repaired satisfactorily. During cross-examination, he agreed that the injuries were consistent with a forceps delivery. However, in re-examination by D1's counsel, Dr Murali did an about turn and said that in his opinion that he does not think that the injury was related to the forceps delivery.

[141] Dr Hu Shan (SP2) saw Mdm Baljeet after a history of five and a half weeks of vulva and perineum pain. Dr Hu Shan found on pelvic inspection, there is a 2cm hole at her perineum and on examination under general anesthetic found: (a) a midline poorly healed scar close to the anus; (b) second degree perineum muscle defect 1.5cm width and 2cm long hole in the perineum muscle; (c) first degree high vagina tear, where active bleeding was seen; and (d) Nabothian abscess and cervicitis.

[142] D1 submits that when Dr Kamaljit Kaur (SD3), the doctor who was covering for D1 when she was on leave from 16 May 2014 to 18 May 2014, checked Mdm Baljeet on 16 May 2014, she found that Mdm Baljeet's perineum was clean. Dr Kamaljit was asked by D1's counsel during examination in chief what she meant by the perineum is 'clean'. Dr Kamaljit answered 'Clean in the sense that there was no redness and there was no pus and there was no active bleeding. There was as lochia though, lochia which would be normal for a person who has just delivered vaginally or by a c-section, in any case. So post-delivery, lochia would be normal'. Dr Kamaljit confirmed during cross-examination that the injury to the perineum had been sutured when she saw Mdm Baljit.

[143] D1's case is that since Dr Kamaljit saw it fit to discharge Mdm Baljeet on two days after the delivery on 16 May 2014, the need to seek medical treatment five weeks later was due to Mdm Baljeet's own actions, namely, in failing to allow natural healing and in not caring for her own hygiene. D1 pleads contributory negligence on the part of Mdm Baljeet and submits that the entire treatment by Dr Hu Shan was not related to D1 but was contributed by Mdm Baljeet's lack of care of her own condition. D1 alleges that there was break in the chain of causation from the time Mdm Baljeet suffered the perineal and vaginal tears as a result of the delivery and the injury as found by Dr Hu Shan as reported in her report dated 19 June 2014. D1 alleges the injury was caused by Mdm Baljeet undertaking excessive physical exercise after delivery or that exercises caused the bleeding.

[144] However, D1 failed to support her allegation that the injury was caused by Mdm Baljeet undertaking excessive physical exercise after delivery or that exercises caused the bleeding. D1 did not provide any evidence showing that Mdm Baljeet undertook exercises in the five weeks after delivery or that the bleeding was caused by exercises instead of the perineal and vaginal tears suffered during delivery. D1's witness, the lactation consultant, Elizabeth Pithchaimuthu (SD6) testified that Mdm Baljeet had asked her about exercises, planking and wall-pumping, *after* she had seen Dr Hu Shan at Damansara Specialist Hospital. SD6 testified that before seeing Dr Hu Shan, Mdm Baljeet did not ask her about exercise and that she mainly asked about breast feeding.

[145] D1 had a duty of care to correctly to identify, treat and managed the injuries suffered by Mdm Baljit as a result of the delivery. For the reasons above, I find that she had failed to discharge this duty according to the requisite standard of care and this failure had caused Mdm Baljeet to suffer the injuries detailed by Dr Hu Shan in her report dated 19 June 2014; which injuries required the repair the operation to be undertaken by Dr Hu Shan.

[146] Further, I find that D1 had failed to discharge the burden of proving her claim that there was a break in the chain of causation from the time Mdm Baljeet suffered the perineal and vaginal tears during the delivery and the injuries detailed in Dr Hu Shan's report.

7. FINDINGS OF COURT: LIABILITY OF D1

[147] For the reasons discussed above, this court finds that D1 had a duty to advise Mdm Baljeet of the available delivery options and the pros and cons of each delivery option. She also had a duty to advise Mdm Baljeet that of the likelihood that Gurisha will be a macrosomic baby and the risk of shoulder dystocia in the vaginal delivery of macrosomic babies. The evidence shows that

D1 had failed to provide Mdm Baljeet with the necessary information to enable her to make an informed decision as to her choice of delivery.

[148] Additionally, this court finds that D1 had breached her duty of care in managing the shoulder dystocia incident during the delivery and that she had failed to apply the requisite standard of care in delivering baby Gurisha. This court further finds that D1's breach of her duty of care had caused Gurisha to suffer brachial plexus injury to her left shoulder and Mdm Baljeet to suffer a second-degree tear to her perineum.

[149] As regards the injuries to Mdm Baljeet, this court finds that D1 had failed to sufficiently identify, treat and manage the perineal injuries suffered by Mdm Baljeet, which resulted in her suffering the injuries detailed in Dr Hu Shan's report and having to undergo the repair surgery conducted by Dr Hu Shan.

[150] Additionally, for the reasons discussed above in section 6(d) of this judgment, this court finds that D1 had failed to prove that Mdm Baljeet was contributorily negligent for the injuries suffered by Gurisha and herself.

[151] Accordingly, this court finds that D1 is 100% liable for the injuries suffered by both Gurisha and Mdm Baljeet.

8. CLAIM AGAINST PANTAI MEDICAL CENTRE SDN BHD (D2)

[152] The plaintiffs' case against Pantai Medical Centre Sdn Bhd (D2) are that: (a) D2 was negligent; (b) D2 was vicariously liable for the D1's negligence and for the negligence of its nurses and agents; and (c) D2 owed the plaintiffs' a non-delegable duty of care.

(a) Negligence

(i) Was D2 negligent? If yes, were the plaintiffs' injuries caused by D2's negligence?

[153] It is a well-established principle of law that liability for a tortious act is based on the tortfeasor's fault. The only exceptions to this common law principle are vicarious liability and the existence of a non-delegable duty of care.

[154] Accordingly, in order for this court to find that D2 was negligent and liable for the injuries suffered by the plaintiffs, the plaintiffs must prove that: (a) D2 owed each of them a duty of care; (b) that duty care was breached; (c) the

plaintiffs suffered the injuries as result of D2's breach of the duty of care; and (d) an the injuries were not too remote.

[155] The plaintiffs have particularised in their statement of claim multiple allegations of negligence against D2 relating to, inter alia, the following:

(a) arrangement for a pediatrician during and after delivery;

(b) provision of advice and information to patients including Mdm Baljeet and her family members;

(c) training and experience of obstetric team;

(d) documentation of Mdm Baljeet's history and condition; and

(e) availability of correct set of forceps during delivery.

(ii) Arrangement for a pediatrician

[156] As regards the arrangement for a pediatrician, the plaintiffs alleged that D2 'failed to have a safe and reliable system to arrange for a pediatrician to be present during the delivery' and 'delayed in having a pediatrician to attend to the first plaintiff soon after her delivery'.

[157] The plaintiffs' own expert witness, Dr Milton Lum, testified that a consultant such as D1 is at liberty to engage a pediatrician to attend to a delivery. And the evidence shows that D1 had arranged for pediatrician, Dr Chai Pei Fan (SP1) to be on standby in the afternoon of 14 May 2014 during the delivery and that the midwives had called SP1 at 6.25pm soon after delivery and informed him that there was difficulty in the delivery of the baby with respect to the shoulder.

[158] The duty is on D1 to arrange for a pediatrician to be on standby during delivery and to request for a pediatrician to attend to Gurisha after the delivery. Both of which she did. The duty is not D2's.

[159] For these reasons, I find that there was no failure or delay on the part of D2 in arranging for a pediatrician to be present during the delivery and that there was no delay on the part of D2 in having a pediatrician to attend to Gurisha after her delivery.

(iii) Duty to advise and duty to document Mdm Baljeet's obstetric history

[160] Pursuant to the consultant agreement's dated 1 December 2014 between the D1 and D2 ('consultant agreement'), D1 was at all material times an independent contractor and not an employee of D2 or Pantai Hospital. It is

expressly stated in the consultant agreement the D1 is a licensed and registered medical practitioner, properly qualified in the discipline of obstetrics and gynaecology. For the reasons discussed below, D1's medical practice, adopting the phrase used by the UK Supreme Court in *Cox v Ministry of Justice* [2016] AC 660 and the Federal Court in *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal* [2018] 1 MLJ 685; [2017] 10 CLJ 529, is a 'recognisably independent business'.

[161] Clause 2(a) of the consultant agreement expressly states that D1 is free to run her medical specialist practice at Pantai Hospital KL without undue interference or interruption from D2. D1 herself testified for as long as she had been practicing in Pantai Hospital KL, the hospital's management had never got itself involved in her antenatal consultations. Furthermore, as a registered medical practitioner, the obligation to advise, diagnose and treat Mdm Baljeet including to document her obstetric history is with D1. It is not with D2 who is the owner of Pantai Hospital KL, a private healthcare facility licensed under the Private Healthcare Facilities and Services Act 1998. Dr Lum, the plaintiffs' expert witness, agrees that the duty to advise a patient is with the treating doctor and not the hospital.

[162] Similarly, for the same reasons, the duty to record Mdm Baljeet's obstetric history is D1's and not the hospital's or D2 as the owner of the hospital. D1 testified that each obstetrician in Pantai Hospital KL maintains his/her antenatal records of their patients either on a sheet or card.

(iv) Nurses

[163] The plaintiffs contend that there was negligence by the nurses because: (a) Nurse Ng (SD4) did make a record of the attempted Mc Roberts manoeuver; and (b) Nurse Ng (SD4) attempted to have Mdm Baljeet to 'push'.

[164] The facts show that although Nurse Ng did not record the McRoberts manoeuver in the nurse's notes, the manoeuver was recorded by D1 in the Clinical Progress Notes (p 182 of Bundle D). Nurse Ng also testified that they were going to ask Mdm Baljeet to push whilst she was in the McRoberts position, however before they could do so, D1 had managed to pull out the baby. The fact that Nurse Ng did not record the McRoberts manoeuver did not cause the injury to Gurisha and Mdm Baljeet. Also, the fact she had intended to ask Mdm Baljeet to push, but did not, was not the cause of the injuries suffered by Gurisha and Mdm Baljeet.

[165] As mentioned earlier, negligence is fault based. The plaintiffs have the burden of proving that: (a) D2' nurses owed the plaintiffs a duty of care; (b) that they had breached that duty of care; and (c) the breach had caused the

injuries to the plaintiffs. The plaintiffs did not provide any evidence showing that D2's nurses' failure to record the McRoberts manoeuver in the nurse's notes or that they had intended to ask Mdm Baljeet to push while she was in the McRoberts position had caused or materially contributed to the plaintiffs' injuries.

[166] Therefore, this court finds that the plaintiffs have not proven that the nurses employed by D2, who had assisted D1 with the delivery of Gurisha, were negligent. Moreover, even if the nurses were negligent, the plaintiffs have not discharged the burden of proving that the nurses' negligence had caused or materially contributed to the plaintiffs' injuries.

(b) Vicarious liability

(i) What does 'vicariously liability' mean?

[167] Vicarious liability together with non-delegable duty of care are exceptions to the long-established principle of law that liability in tort is fault based. Lord Sumption in *Woodland v Swimming Teachers Association and others* [2014] AC 537 ('*Woodland*') explained the concept of vicarious liability as follows:

> 3. In principle, liability in tort depends upon proof of a personal breach of duty. To that principle, there is at common law only one true exception, namely vicarious liability. *Where a defendant is vicariously liable for the tort of another, he commits no tort himself and may not even owe the relevant duty, but is held liable as a matter of public policy for the tort of the other: Majrowski v Guy's and St Thomas's NHS Hospital Trust* [2005] QB 848. *The boundaries of vicarious liability have been expanded by recent decisions of the courts to embrace tortfeasors who are not employees of the defendant, but stand in a relationship which is sufficiently analogous to employment: Various Claimants v Catholic Child Welfare Society and others* [2013] 2 AC 1. *But it has never extended to the negligence of those who are truly independent contractors*, ... (Emphasis added.)

[168] It is a long-established principle of law that an employer, though himself not personally at fault for a tortious act, may be liable for the tortious act of his employee committed during the course of his employment. Over the years, the courts have expanded the law on vicarious liability.

[169] The boundaries of vicarious liability have been extended in the last decade by the UK Supreme Court in *Various Claimants v Catholic Child Welfare Society and others* [2013] 2 AC 1 ('the *Various Claimants* case') to include tortfeasors who are not employees of the defendant but to those 'in a relationship which is sufficiently analogous to employment'. Lord Phillips summarised the development in his judgment, which was the main judgment

in the *Various Claimants* case as below, which Lord Phillips held 'represent sound and logical incremental developments of the law':

> 20 Since Ward LJ and I cut our teeth the courts have developed the law of vicarious liability by establishing the following propositions:
>
> (i) It is possible for an unincorporated association to be vicariously liable for the tortious acts of one or more of its members: *Heaton's Transport (St Helens) Ltd v Transport and General Workers' Union* [1973] AC 15, 99; *Thomas v National Union of Mineworkers (South Wales Area)* [1986] Ch 20, 66–7; *Dubai Aluminum Co Ltd v Salaam* [2002] UKHL 48; [2003] 2 AC 366.
>
> (ii) D2 may be vicariously liable for the tortious act of D1 even though the act in question constitutes a violation of the duty owed to D2 by D1 and even if the act in question is a criminal offence: *Morris v CW Martin & Sons Ltd* [1966] 1 QB 716; *Dubai Aluminium; Brink's Global Services v Igrox* [2010] EWCA Civ; [2011] IRLR 343.
>
> (iii) Vicarious liability can even extend to liability for a criminal act of sexual assault: *Lister v Hesley Hall* [2001] UKHL 22; [2002] 1 AC 215.
>
> (iv) It is possible for two different defendants, D2 and D3, each to be vicariously liable for the single tortious act of D1: *Viasystems (Tyneside) Ltd v Thermal Transfer (Northern) Ltd and others* [2005] EWCA Civ 1151; [2006] QB 510.

[170] The question as regards the extension of the doctrine of vicarious liability was posed to Federal Court in *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal* [2018] 1 MLJ 685; [2017] 10 CLJ 529, which question was as follows:

> Whether the criteria for imposing vicarious liability set out by Lord Phillips in the decision of the Supreme Court of UK in *Various Claimants v Catholic Child Welfare Society and Others* [2013] 2 AC 1 and as further explained and elaborated by the Supreme Court of UK in *Cox v Ministry of Justice* [2016] AC 660 and *Mohamud v WM Morrison Supermarkets Plc* [2016] AC 677 applies in Malaysia?

The Federal Court held that:

> [90] With these modifications, we would adopt the stage 1 test in *Various Claimants* as elaborated upon in *Cox* and answer the third question in the affirmative in that respect. In relation to the stage 2 test in *Various Claimants* as explained in *Mohamud*, we note that the test is developed in the context of, and to cater for, intentional torts committed by employees. Since such an issue does not arise in the present case, we would leave open the question of the applicability of the stage 2 test at this juncture.

[171] In the *Various Claimants* case, Lord Phillips had set out a two-stage test in determining whether vicarious liability should be imposed, namely '(1) was there a true relationship of employer/employee between D2 and D1? (2) was

D1 acting in the course of his employment when he committed the tortious act?'.

[172] The Federal Court in *Dr Kok Choong Seng* summarised the two-stage test described by Lord Phillips in the *Various Claimants* case for imposing vicarious liability on the employer for the tortious act of the employee as follows:

> [74] In relation to stage 1, His Lordship identified a number of criteria which, when satisfied, 'give rise to policy reasons that make it fair, just and reasonable to impose vicarious liability on the employer':
>
> (i) The employer is more likely than the employee to have the means to compensate the victim, and can be expected to be insured;
>
> (ii) The tort was committed as a result of the employee's activity done on behalf of the employer;
>
> (iii) The employee's activity was part of the employer's business activity;
>
> (iv) By employing the employee to carry on the activity, the employer has created the risk of the tort committed by the employee; and
>
> (v) The employee was under the control of the employer, to a greater or lesser degree. Since many skills in modern employment are not susceptible to direction, the significance of control is that the employer can direct what the employee does, not how he does it.
>
> ...
>
> [77] At stage 2, Lord Phillips found that the requirement for the tortious act to be done 'in the course of employment' would plainly be satisfied where the employee does negligently what he is employed to do. However, in the context of sexual abuse cases, His Lordship explained that the essential closeness of connection between relationship and abuse is satisfied where an employer uses the employee to carry on its business or further its own interests, in a manner which has created or significantly enhanced the risk of abuse. The creation of risk is not enough of itself to give rise to liability, but is an important element for consideration.

[173] Both stages of the test in the *Various Claimants* case were refined by the UK Supreme Court in *Cox v Ministry of Justice* [2016] AC 660 and *Mohamud v WM Morrison Supermarkets plc* [2016] AC 677. Lord Reed, who delivered the main judgment of the Supreme Court in *Cox*, reiterated that the scope of vicarious liability depends on the answers to both stages of the two-stage test in the *Various Claimants* case, namely:

(a) the type of relationship that exists between a person and a defendant before the defendant can be made liable for the tortious act of the person; and

(b) in what manner does the conduct of the person have to be related to that relationship in order for vicarious liability to be imposed on the defendant.

[174] The appeal in *Cox* was concerned with the first stage of the test. Lord Reed held that the five criteria listed by Lord Phillips in the *Various Claimants* case for the first stage, are not all equally significant. His Lordship held that the first criteria (ie the employer's means to compensate) 'is unlikely to be of independent significance in most cases'. Lord Reed held that the fact that an employer is likely to have a deeper pocket or had insured against vicarious liability are 'not a principled justification for imposing vicarious liability'. His Lordship held:

> *The mere possession of wealth is not in itself any ground for imposing liability*. As for insurance, *employers insure themselves because they are liable: they are not liable because they have insured themselves*. On the other hand, given the infinite variety of circumstances in which the question of vicarious liability might arise, *it cannot be ruled out that there might be circumstances in which the absence or unavailability of insurance, or other means of meeting a potential liability, might be a relevant consideration*. (Emphasis added.)

[175] As for the fifth criteria (ie the employer's degree of control over the employee), Lord Reed agreed in *Cox* with Lord Phillips in that the degree of control an employer has over an employee is 'no longer has the significance that it was sometimes considered to have in the past'. Lord Phillips had explained in para 36 of his judgment in the *Various Claimants* case that it is not realistic in modern life to look for a right to direct how an employee should perform his duties as a necessary element in the relationship between employer and employee. And that the significance of control is that the defendant can direct what the tortfeasor does, not how he does it. Lord Reed in *Cox* held that degree of an employer's control 'is a factor which is unlikely to be of independent significance in most cases'. But on the other hand, 'the absence of even that vestigial degree of control would be liable to negative the imposition of vicarious liability'.

[176] Lord Reed went on to hold that the remaining criteria set out by Lord Phillips in the *Various Claimants* case ie the second criteria (ie the tort will have been committed as a result of activity undertaken by the tortfeasor on behalf of the defendant), the third criteria (ie the tortfeasor's activity is likely to be part of the business activity of the defendant) and the fourth criteria (ie the defendant, by employing the tortfeasor to carry on the activity, will have created the risk of the tort committed by the tortfeasor) criteria are inter-related. His Lordship said as regards these inter-related criteria:

> 24 Lord Phillips's analysis in the Christian Brothers case (*Various Claimants*) wove together these related ideas (the second, third and fourth criteria) so as to develop a

A modern theory of vicarious liability. The result of this approach is that a relationship other than one of employment is in principle capable of giving rise to vicarious liability where harm is wrongfully done by an individual who carries on activities as an integral part of the business activities carried on by a defendant and for its benefit (rather than his activities being entirely attributable to the conduct of a recognisably B independent business of his own or of a third party), and where the commission of the wrongful act is a risk created by the defendant by assigning those activities to the individual in question.

[177] Therefore, whilst the UK Supreme Court in *Cox* agrees with the *Various* C *Claimants* case that the scope of vicarious liability can be extended to harm that is wrongfully caused by a tortfeasor who carries on activities as an integral part of the employer's business activities and for its benefit, Lord Reed expressly stated in *Cox* that this extension of the scope of vicarious liability is not without limit. He held that no liability is imposed where the tortious act is entirely D attributable to the 'recognisably independent business' of the tortfeasor or a third party.

[178] The second stage of the test in the *Various Claimants* case was considered by the Supreme Court in *Mohamud v WM Morrison Supermarkets* E *Plc* as regards a tort committed by an employee. Our Federal Court in *Dr Kok Choong Seng* left the question of imposing vicarious liability on the second stage of the test open because it noted 'that the test is developed in the context of, and to cater for, intentional torts committed by employees', whilst the issue for determination in *Dr Kok Choong Seng* was vicarious liability for the tortious act F of an independent contractor.

[179] In *Dr Kok Choong Seng* on the question of:

> Whether private hospitals in Malaysia such as the appellant hospital can or should G be held vicariously liable for the tortious conduct or clinical negligence of medical doctors vis a vis their patients while practising at such private hospitals as independent contractors?

The Federal Court held that:

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> [96] ... the vicarious liability of private hospitals cannot be rejected wholesale on the basis that the respective roles of the hospitals and medical practitioners are distinct and rigidly delineated by statute; as we have canvassed, such an interpretation is unsupported by the relevant legislation. As discussed earlier, neither can the means of compensation by the hospital or the practitioner be in itself determinative of I vicarious liability.
>
> [97] The test for vicarious liability in *Various Claimants* requires the court to determine the nature of the relationship between the hospital and the medical practitioner, and the connection between that relationship and the wrongful act by the practitioner. The determination is a question of fact, based on a consideration of

multiple factors and calls for an evaluative judgment. The terms regulating the general relationship between a hospital and a practitioner, and the particular terms applicable in the circumstances of the alleged negligence, may vary from case to case. As such, the vicarious liability of the private hospitals for the torts of medical practitioners cannot be determined with a broad brush in a factual vacuum.

[180] Upon applying the first stage of the test in the *Various Claimants* case, the Federal Court found that the relationship between the hospital and Dr Kok is not sufficiently akin to employment so as to give rise to vicarious liability for Dr Kok's negligence in conducting the operation. The Federal Court went on to hold that since there is no relationship between the hospital and Dr Kok that is sufficiently akin to employment, the second stage of the test does not arise.

(ii) Is D2 vicariously liable for D1's negligence?

[181] In this instant case, the consultant's agreement between D1 and D2 dated 1 December 2014 ('consultant agreement') provides that:

(a) D1 at all material time was an independent contractor and not a servant of D2 (cl 9.1);

(b) D2 does not pay any salary or allowance to D1 and D1 is not entitled to any statutory benefits or contributions which paid or provided to D2's employees (cl 9.3);

(c) D2 shall assist D1 and provide the necessary back-up services for D1's consultancy services (cl 2(b));

(d) D1 enjoys the rights and freedom to operate her medical specialist service at Pantai Hospital KL without undue interference and interruption (cl 2(a));

(e) D1 shall endeavour to use Pantai Hospital KL's facilities in the treatment of her patients, subject to the best interests of the patient (cl 3(f) and 3(n));

(f) D1 is to be on call rotation at such time and for such period and hold a number of clinical sessions as required by Pantai Hospital KL (cl 3(g)); and

(g) D1 may charge professional fees for consultation and procedures, whereas D2 may levy operational, administrative or other fees (cll 4.1, 4.2(a) and 4.2(b)).

[182] Applying the first stage of the test in the *Various Claimants* case to this instant case, I find that it is evident from the terms of the consultant agreement that D1's medical and clinical services are generally not subject to D2's control or interference. D1 during the trial admitted her status as an independent

A contractor at Pantai Hospital KL and testified that D2 had never interfered in the manner she advised a patient or her treatment and diagnosis of a patient. She also said that D2 had never exerted any control in how she interacted with a patient and agreed that D2 had left all clinical issues and medical treatment in her hands.

B

[183] The facts show that neither Pantai Hospital KL nor D2 had directed, required or instructed D1 to deliver Gurisha by way of an induced vaginal delivery. D1's arrangement with the hospital was only to provide for Mdm Baljeet's admission and to provide the necessary facilities and nurses to assist with the labour and delivery. As held by Lord Reed in *Cox* and Raus Sharif CJ in *Dr Kok Choong Seng*, the absence of even a 'vestigial degree of control' by either Pantai Hospital KL over D1's conduct during the labour and delivery of Gurisha negates any vicarious liability on D2's part for D1's negligence.

C

D

[184] Gurisha's delivery by way of an induced vaginal delivery was not undertaken on behalf of Pantai Hospital KL but was attributable to D1's 'recognisably independent business'. The UK Supreme Court in *Cox* held that no liability is imposed where the tortious act is entirely attributable to the 'recognisably independent business' of the tortfeasor. Similarly, the Federal Court in *Dr Kok Choong Seng*, found that Dr Kok carried out a 'recognisably independent business' and held that the hospital in that case was not vicariously liable for Dr Kok's tortious act.

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[185] Furthermore, the diagnosis of Mdm Baljeet's condition, the advice to undergo the induced vaginal delivery and Mdm Baljeet's referral to Pantai Hospital KL were not carried out in the course of on-call rotations or clinical sessions required by the hospital. They were all done by D1 in the course of her own practice in her private clinic. In *Dr Kok Choong Seng*, the Federal Court held that the fact that Dr Kok charges consultancy and operation fees for his patients, and receives no salary from the hospital, lends further weight to the inference that the operation was part of Dr Kok's independent business. Similarly, in this instant case, as is evident from the facts and the terms of the Consultancy Agreement, D1 charges consultancy and delivery fees to her patients. She also receives no salary or allowance from D2. Accordingly, it can be inferred that the management of Mdm Baljeet's labour and the delivery of Gurisha was part of D1's independent business.

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[186] For these reasons, I find that D1 is an independent contractor practicing in Pantai Hospital KL and that she is not an employee of D2. I further find that the relationship between D1 and D2 is not sufficiently akin to employment for D2 to be vicariously liable for D1's negligence in managing Mdm Baljeet labour and delivering Gurisha.

[187] The plaintiffs' claim against D2 for vicarious liability is premised on the plaintiffs discharging their burden of proving that D2's nurses were negligent and their negligence had caused or materially contributed to the plaintiffs' injuries. As this court has found that the plaintiffs have not proven on a balance of probabilities that the nurses were negligent, the plaintiffs claim against D2 for vicariously liability also fails.

(c) Non-delegable duty of care

[188] The plaintiffs claim that D2 owed them a non-delegable duty of care for D1's negligence.

[189] What is a non-delegable duty of care? Lord Sumption in *Woodland*, explained that the expression 'non-delegable duty' has become the conventional way of describing those cases in which the ordinary principle (ie the law of negligence does not in the ordinary course impose personal liability on a person for what others do or omit to do) is displaced and the duty extends beyond being careful, to procuring the careful performance of work delegated to others. Lord Sumption said:

> 5 The law of negligence is generally fault-based. Generally speaking, a defendant is personally liable only for doing negligently that which he does at all, or for omissions which are in reality a negligent way of doing that which he does at all. The law does not in the ordinary course impose personal (as opposed to vicarious) liability for what others do or fail to do. ... *The expression 'non-delegable duty' has become the conventional way of describing those cases in which the ordinary principle is displaced and the duty extends beyond being careful, to procuring the careful performance of work delegated to others*. (Emphasis added.)

[190] Lord Sumption went on to consider in what circumstances will a non-delegable duty of care arise and held as follows:

> 22 *The main problem about this area of the law is to prevent the exception from eating up the rule. Non-delegable duties of care are inconsistent with the fault-based principles on which the law of negligence is based, and are therefore exceptional. The difference between an ordinary duty of care and a non-delegable duty must therefore be more than a question of degree. In particular, the question cannot depend simply on the degree of risk involved in the relevant activity.* The ordinary principles of tortious liability are perfectly capable of answering the question what duty is an appropriate response to a given level of risk.
>
> 23 In my view, the time has come to recognise that Lord Greene in *Gold* and Denning LJ in *Cassidy* were correct in identifying the underlying principle, and while I would not necessarily subscribe to every dictum in the Australian cases, in my opinion they are broadly correct in their analysis of the factors that have given rise to non-delegable duties of care. *If the highway and hazard cases are put to one side, the remaining cases are characterised by the following defining features:*
>
> (1) *The claimant is a patient or a child, or for some other reason is especially*

A *vulnerable or dependent on the protection of the defendant against the risk of injury*. Other examples are likely to be prisoners and residents in care homes.

(2) *There is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places the* B *claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm*, and not just a duty to refrain from conduct which will foreseeably damage the claimant. *It is characteristic of such relationships that they involve an element of control over the claimant,* C which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.

(3) *The claimant has no control over how the defendant chooses to perform those obligations, ie whether personally or through employees or through third parties.*

D

(4) *The defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant*; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it.

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(5) *The third party has been negligent* not in some collateral respect but *in the performance of the very function assumed by the defendant and delegated by the defendant to him.* (Emphasis added.)

F **[191]** The Federal Court in *Dr Kok Choong Seng* considered whether: (a) the doctrine of non-delegable duty of care expounded in *Woodland* applies in Malaysia; and (b) if yes, whether the doctrine of non-delegable duty of care can or should apply to private hospitals 'such that those hospitals would be held liable for the tortious conduct or clinical negligence of medical doctors vis a vis their patients while practising there as independent contractors?'. G

[192] On the first question, the Federal Court held that the doctrine of non-delegable duty of care applies in Malaysia. The court held that:

> non-delegable duties are characterised as arising from an assumption of H responsibility imputed to the defendant, by virtue of his special relationship with the claimant.

[193] Raus Sharif CJ in in *Dr Kok Choong Seng* highlighted that Lord Sumption in *Woodland* had stressed that non-delegable duties of care I should be imputed 'only so far as it would be fair, just and reasonable'; and that Lady Hale had emphasised that the boundaries of the responsibility undertaken may not always be clear cut, but will have to be ascertained on a case by case basis plus there is the need for caution in developing the law beyond chartered waters.

[194] At para 40 of the Federal Court's judgment, Raus Sharif CJ reiterated the proviso in *Woodland* that:

> *such duties [non-delegable duty of care] should only be imposed where it is fair, just and reasonable to do so based on the particular circumstances of the case*, and developed incrementally from existing categories and consistently with underlying principles. (Emphasis added.)

[195] His Lordship also pointed out that the Singapore Court of Appeal in *Management Corporation Strata Title Plan No 3322 v Tiong Aik Construction Pte Ltd and another* [2016] 4 SLR 521; [2016] SGCA 40, while confirming their approval of the test set out in *Woodland* for determining where non-delegable duty arises, cautioned that the court would have to take into account 'the fairness and reasonableness of imposing a non-delegable duty in the particular circumstance, as well as the relevant policy considerations in our local context'.

[196] The Federal Court found that the consultant Dr Kok Choong Seng, a consultant orthopaedic surgeon was solely liable for the injuries suffered by the patient. It held that the hospital, Sunway Medical Centre Bhd, was not in breach of a non-delegable duty of care.

(i) Does D2 owe the plaintiffs a non-delegable duty of care?

[197] The decisions of the UK Supreme Court in *Woodland*, the Singapore Court of Appeal in *Management Corporation Strata Title Plan No 3322 v Tiong Aik Construction Pte Ltd and another* and our Federal Court in *Dr Kok Choong Seng*, make it clear that:

(a) non-delegable duty and vicarious liability are exceptions to the fault-based principle of the law of tort;

(b) courts are to assess whether a non-delegable duty arise based on the particular set of facts and circumstance of each case;

(c) a claimant alleging that the defendant owes it a non-delegable duty of care must, at the very least satisfy, the court that the facts fall within one of the two categories of non-delegable duties set out by Lord Sumption in *Woodland*;

(d) for the second category of non-delegable duty, the facts must possess all the five defining features listed in *Woodland*; and

(e) in determining whether a non-delegable duty exists, the court must to take into account the fairness and reasonableness of imposing a non-delegable duty based on the facts and circumstance of the case.

[198] In this present case, Mdm Baljeet had personally chosen D1 based on her fertility doctor's (Dr Prashant) advice. She agreed during cross-examination that her focus was who was going to be her consultant obstetrician and not the hospital. When asked by D2's counsel 'if Dr Premitha was in a different hospital, you would have gone to that hospital, would that be correct?', Mdm Baljeet replied 'Yes, that's true'.

[199] During her admission into Pantai Hospital KL for induction of labour on 13 May 2014, Mdm Baljeet's husband had signed D2's Terms and Conditions of Service, which included among others the following terms:

> 4. MEDICAL CONSULTANTS AS INDEPENDENT MEDICAL PRACTIONERS AT THE HOSPITAL
>
> The undersigned agrees and accepted that all medical consultants or healthcare professional who have practicing rights at the Hospital are *independent medical practitioners and are not employees of the Hospital.* The undersigned also agrees, understand and accepts that it is the sole responsibility of the medical consultants or healthcare professional to obtain the Patient's Informed Consent. The undersigned further irrevocably agrees that the Costs of the Services rendered by the medical consultants or healthcare professionals shall be collected by the Hospital and that the Hospital shall have all legal rights to recover the Cost in the Hospital's own name at all times.

[200] Mdm Baljeet confirmed during cross-examination that she is aware that D1 was an independent contractor in Pantai Hospital KL.

[201] From the facts of the case surrounding P2's engagement of D1, it can be inferred that Mdm Baljeet had expected that D1 will provide Mdm Baljeet with ante-natal care and manage her labour and delivery of baby Gurisha with due care and accordingly to the applicable standard of care.

[202] D2 had not assumed a positive duty in respect of the conduct of D1's treatment and management of the plaintiffs. In accordance with the terms of the consultant agreement, D2 merely provided the relevant facilities required for her admission, labour and delivery of Gurisha. Both Mdm Baljeet and her husband were aware that D1 is an independent contractor practicing at Pantai Hospital KL and is not an employee of the hospital or D2. Mdm Baljeet confirmed that she had chosen D1 and not Pantai Hospital KL to provide her with the ante-natal care and for the delivery of her baby.

[203] From the evidence presented, I find that there is no antecedent relationship between Mdm Baljeet and the hospital. It can be inferred from the facts of this case that Mdm Baljeet had reasonably expected that D1 would give her the necessary advice and information so as to enable her to make an informed decision and give an informed consent on the mode of delivery, and

that D1 would manage and conduct the delivery of her baby with due care. Pantai Hospital KL was only to provide the relevant staff to assist D1 and the relevant facilities required for Mdm Baljeet's admission, induction of labour and delivery.

[204] For these reasons, I find that it is not possible to impute on D2 a positive duty to protect the plaintiffs from injury during the labour and delivery. As held by the UK Supreme Court in *Woodland* and accepted by the Federal Court in *Dr Kok Choong Seng*, relationships where there is an assumption of a positive duty to protect the claimant from harm, must involve an element of control by the defendant over the claimant. In this instant case, I find that there was no element of control by D2 over the plaintiffs.

[205] In order to establish a prima facie case that a defendant owes a claimant a non-delegable duty of care in non-hazardous cases, it is necessary that the facts possess the five defining features listed in *Woodland*. The Federal Court in *Dr Kok Choong Seng* held that once the second feature of the *Woodland* test is not satisfied, the remaining questions no longer arise. The Federal Court found that the hospital in that case did not owe the plaintiff a non-delegable duty of care. Raus Sharif CJ held:

> [68] As such, we find that the second feature in the *Woodland* formulation is not satisfied on the facts. Since the hospital had not assumed a positive duty in respect of the conduct of the operation, the questions of how the hospital chooses to perform the duty (the third feature), the hospital's delegation of an integral part of that duty (the fourth feature), and the delegatee's negligence in the performance of the duty (the fifth feature) do not arise.

[206] In *Dr Kok Choong Seng*, on the second question of whether the non-delegable duty of care as expounded in *Woodland* can or should apply to private hospitals such that those hospitals would be liable for the tortious acts or clinical negligence of medical doctors vis a vis their patients while practicing there as independent contractors, the Federal Court held that:

> [70] ... given the fact-sensitive nature of the *Woodland* test, *whether private hospitals are in breach of a non-delegable duty to their patients by reason of the negligence of doctors practising there cannot be predetermined by a general pronouncement, but assessed based on the facts and circumstances of each case.* We are satisfied that the defining features of non-delegable duties identified in *Woodland* are not present in the instant case, and accordingly we find the hospital not liable for breach of a non-delegable duty to the plaintiff. (Emphasis added.)

[207] For these reasons, I find that based on the facts and circumstance of this case a non-delegable duty of care by D2 to the plaintiffs does not arise. Accordingly, D2 is not in breach of a non-delegable duty of care.

9. FINDINGS OF COURT: LIABILITY OF D2

[208] For the reasons above, I find that D2 is (a) not negligent for the injuries suffered by the plaintiffs, (b) is not vicariously liable for D1's negligence; and (c) does not owe the plaintiffs a non-delegable duty of care and is accordingly, not in breach of a non-delegable duty of care.

10. QUANTUM OF DAMAGES

> Perfect compensation is hardly possible, and would be unjust. You cannot put the Plaintiff back again into his original position.

[209] These are the words of Baron Peake used by Field J in his summing to the jury in *Phillips v London & South Western Railway* (1879) 5 QBD 78, which is oft-quoted as showing the right direction to be given to a jury when they are awarding compensation for personal injuries.

[210] In his famous summing up to the jury, Field J said:

> it has been pointed out for centuries, and it is the principle of foreign jurisprudence as well as ours, that *in actions for personal injuries of this kind, as well as in many others, it is wrong to attempt to give an equivalent for the injury sustained*. I do not mean to say that you must not do it, because you are the masters and are to decide; but I mean that it would operate unjustly, and in saying so I am using the language of the great Baron Parke, whose opinion was quoted with approval in *Rowley's* case. '*Perfect compensation is hardly possible, and would be unjust*'. In *Rowley's* case (*Rowley v London and North Western Railway Co* (1873) LR 8 Ex 221), Brett J had approved of and laid down the rule as declared by Baron Parke that the jury *'must not attempt to give damages to the full amount of a perfect compensation for the pecuniary injury, but must take a reasonable view of the case, and give what they considered under all the circumstances a fair compensation'.* (Emphasis added.)

[211] Field J's direction was approved by Cockburn CJ in *Phillips v London & South Western Railway* (1879) 4 QBD 406, who added another reason:

> The compensation should be commensurate to the injury sustained. But there are personal injuries for which no amount of pecuniary damages would afford adequate compensation, while, on the other hand, the attempt to award full compensation in damages might be attended with ruinous consequences to defendants. ... Generally speaking, we agree with the rule as laid down by Brett J. in *Rowley v London and North Western Ry Co* (1873) LR 8 Ex 221 ... that a jury in these cases 'must not attempt to give damages to the full amount of a perfect compensation for the pecuniary injury, but must take a reasonable view of the case, and give what they consider under all the circumstances a fair compensation.

[212] The aforementioned passages were quoted with approval by Lord Devlin in *West (H) & Son Ltd and another v Shephard* [1964] AC 326 and

Lord Denning MR in *Fletcher v Autocar & Transporters, Ltd* [1968] 1 All ER 726; [1968] 2 QB 322, where he said 'undoubtedly represent the law'.

[213] It is evident from these passages as quoted and approved by the English House of Lords and Court of Appeal that the overarching common law principle as regards the assessment of damages for personal injuries is that damages are not punishment for the defendant's tortious act and are not a reward to the plaintiff for the injuries suffered. The courts should take a reasonable view and award a fair compensation in the circumstances.

[214] This common law principle has been adopted and repeated time and again by our Federal Court in their judgments. In *Ong Ah Long v Dr S Underwood* [1983] 2 MLJ 324; [1983] 2 CLJ 198; [1983] CLJ Rep 300, Syed Agil Barakbah FJ in the judgment of the Federal Court explained the principle as follows:

> *It has to be borne in mind that damages for personal injuries are not punitive and still less a reward. They are simply compensation that will give the injured party reparation for the wrongful act and for all the natural and direct consequences of the wrongful act*, so far as money can compensate. *British Transport Commission v Gourley* and *HW West & Son Ltd. v Shephard* [1963] 2 All ER 625. *The award under general damages should be a global sum commensurate with the injury sustained and not a full compensation which might result in ruinous consequences to the defendant* (per Sir Alexander Cockburn, LJ in *Phillips v South Western Railway Co* [1879] 4 QBD 406). (Emphasis added.)

[215] In a more recent Federal Court decision in *Inas Faiqah bt Mohd Helmi (an infant suing through her father and next friend, Mohd Helmi bin Abdul Aziz) v Kerajaan Malaysia & Ors* [2016] 2 MLJ 1; [2016] 2 CLJ 885, Abdull Hamid Embong FCJ in delivering the judgment of the Federal Court said:

> [20] It is trite that damages serve as compensation, not a reward, less still a punishment (see *Ong Ah Long v Dr S Underwood* [1983] 2 MLJ 324; [1983] 2 CLJ 198; [1983] CLJ Rep 300). In assessing damages, the court should not be motivated by sympathy and award fair compensation based on cogent evidence ...

[216] In *Inas Faiqah bt Helmi*, the Federal Court also considered the question of the standard of proof for future damage. It held that

> [23] This civil standard of proof is emphasised in the recent decision of this court in *Sinnaiyah & Sons Sdn Bhd v. Damai Setia Sdn Bhd* [2015] 5 MLJ 1; [2015] 7 CLJ 584; (02(f)-72–10 of 2013(A), 10 August 2015), a case concerning the standard of proof for fraud in civil claims, where it was held that:
>
> > At law there are only two standards of proof, namely beyond reasonable doubt for criminal cases while it is on a balance of probabilities for civil cases. As such even if fraud is the subject in a civil claim, the standard of proof is on a balance of probabilities. There is no third standard.

A [24] With the above proposition, *we are of the view that the standard of proof with regard to the assessment of future loss or damage is on the balance of probabilities, but with a lower degree of certainty as to the occurrence of such loss or damage in the future*. From the authorities, one can say that such a lower degree to be attached is best termed by the word 'possibility', 'chance', 'risk', 'danger' or 'likelihood', *but* B *regardless of the words used and their semantics, they must also essentially be a substantial one and not speculative, and that the standard of proving such 'possibility', 'chance', 'risk', 'danger' or 'likelihood' of the future damage is still, in our opinion, on a balance of probabilities*. (Emphasis added.)

C **[217]** As held above, this court has found that first plaintiff, Gurisha, had suffered branchial plexus injury and the second plaintiff, Mdm Baljeet had suffered a second-degree tear to her perineum and tears to her vagina which necessitated an operation by Dr Hu Shan to repair the injuries caused by D1's negligence. For the reasons stated in this judgment, I had found that D1 is D 100% liable for the injuries suffered by the plaintiffs.

[218] After the trial had concluded and parties had made their submissions, counsel for the plaintiffs asked for leave to reopen the trial for the testimony of the plaintiffs' and D1's experts because after the trial, Gurisha's parents were E told by her physiotherapist that Gurisha had developed mild scoliosis.

[219] This court allowed the application. The plaintiffs' expert was Dr Kavitha Uma Ratnalingam (SP6), who is Consultant Rehabilitation F Physician who had testified earlier in the trial and the D1's expert was Datuk Dr Sivananthan Shanmugam (SD9), who is a Consultant Trauma Orthopedic Surgeon.

[220] During the re-opened trial, learned counsel for the plaintiffs, Mr MS G Dhillon said that the Court of Appeal had previously in 'Muthu's case' (Suit No N-04-W-213–05 of 2018) rejected Dr Sivananthan's expert testimony. However, upon reviewing the transcript of the proceedings in the said appeal, it is clear that the Court of Appeal did not reject Dr Sivananthan's testimony. Learned counsel also told Dr Sivananthan that he had criticized other defence H experts in other cases for failing to write down the Mallet score. Mr Dhillon informed this court that he will be providing notes of evidence in the 'Penang' case to 'confront' Dr Sivananthan with. However, up to the date this court delivered its decision, learned counsel did not provide this court with the notes of evidence in the 'Penang case'. I

[221] As the allegations by plaintiffs' counsel against Dr Sivananthan in 'Muthu's case' proved to be without basis and there were no notes of evidence substantiating the allegations in the 'Penang Case', I decided to ignore them. In

doing so, I advised counsels not to make aspersions on the character of an expert witness, particularly when there is no evidence to substantiate such aspersions.

[222] Dr Kavitha concluded that Gurisha has functional scoliosis as opposed to structural scoliosis. When asked by this court of the difference between functional scoliosis and structural scoliosis, Dr Kavitha explained that functional scoliosis means that there is no need to treat the spine and that the spine can be corrected by correcting her posture and strengthening the weak muscles; whereas with structural scoliosis, surgery to the spine is required to correct the spine. Dr Kavitha concluded that no surgical intervention is required to correct the functional scoliosis. It requires the strengthening of her left shoulder muscles.

[223] Dr Kavitha's clinical findings contradicted with what was shown on the x-ray of Gurisha's spine. She had stated that there is mild curve of Gurisha's spine, *convex to the right*. However, Dr Sivanathan testified that looking at the x-ray the spine was *convex to the left*. He demonstrated during the trial with the original x-ray film, a light box and a ruler that Gurisha's spine was shown to convex to the left. During the trial, Dr Kavitha confirmed that she agreed with Dr Sivanathan that looking at the x-ray, *the spine is indeed convex to the left*. She explained that her earlier erroneous finding was based on what was stated by the radiologist.

[224] According to Dr Sivananthan, Gurisha does not have scoliosis presently and that her chances of developing scoliosis in the future is that of any normal girl in her age group. I find that Dr Sivananthan's expert opinion to be reasonable, responsible, respectable and stands up to logical analysis.

[225] Although Dr Kavitha is of the opinion that Gurisha has functional scoliosis and Dr Sivananthan is of the opinion that Gurisha does not have scoliosis, both experts are in agreement that Gurisha does not need any corrective surgery to her spine in the future. They were both of the opinion that Gurisha would only need physiotherapy and exercise to strengthen her left shoulder muscles.

[226] Accordingly, I have awarded the sum of RM15,000 for 100 sessions of physiotherapy as costs of future medical treatment and therapy for Gurisha based on the opinion of both the plaintiffs' and D1's expert that Gurisha needs physiotherapy in order to strengthen her left shoulder muscles.

[227] Based on the available evidence, the testimony of the experts and established principles of law, this court awarded special damages and general damages to the plaintiffs for the items and in the amount set out in Table 1 below:

TABLE 1

ITEM	AMOUNT (RM)
SPECIAL DAMAGES	
(1) Hospital & Medical expenses	22,597.80
(2) Cost of physiotherapy and other rehabilitative treatment incurred by Gurisha	8,728
(3) Cost of special clothes, equipment (corsets, O-rings)	500
(4) Travelling and accommodation expenses	1,000
Total:	32,825.80
GENERAL DAMAGES	
(1) branchial plexus Injury to left shoulder	75,000
(2) cost of future medical and therapy	47,300

(a) Special damages

[228] I have allowed as special damages:

(a) the sum of RM22,597.80 claimed by the plaintiffs for hospital and medical expenses. It includes the sum of RM12,503.70 for the charges and fees of KPJ Damansara Hospital for the repair operation conducted by Dr Hu Shan on Mdm Baljeet;

(b) the whole of the plaintiffs' pleaded sum of RM8,728 as costs of physiotherapy and other rehabilitative treatment incurred by Gurisha;

(c) the whole of the plaintiffs' pleaded sum of RM500 for rubber tubing, bath pods, o-rings used by Mdm Baljeet during her recovery process; and

(d) the whole of the plaintiffs' pleaded sum of RM1,000 for travelling and accommodation expenses.

[229] I have disallowed as special damages:

(a) Mdm Baljeet claims of loss of income of RM68,000, which she contends is her one-month basic salary less tax. It is trite law that a plaintiff must prove her claim on a balance of probabilities and that the court must decide on the appropriate amount of compensation based on available evidence. However, in this instant case, Mdm Baljeet did not provide any evidence of her monthly income whether in the form of a

salary slip or her income tax form in order to prove the amount claimed. For this reason, I disallowed Mdm Baljeet's claim for loss of income; and

(b) the plaintiffs' claim for costs of medicines and nutritional supplement of RM8,000 because there is no medical evidence to support the claim that Gurisha needs medicines and nutritional supplements for the brachial plexus injury she suffered or Mdm Baljeet for the perineum tear that was repaired by Dr Hu Shan.

As a growing child, Gurisha may need medicines and nutritional supplements in general. However, there was no evidence presented to this Court that she needs special medicines and nutritional supplements because of the injury she had suffered. The evidence shows that Gurisha requires therapy for the brachial plexus injury to her left shoulder. All the experts are in agreement that Gurisha's parents had incurred physiotherapy and other rehabilitative treatment for Gurisha's and will incur costs in the future for physiotherapy and medical consultation with orthopaedic consultants and pediatricians.

(b) General damages

[230] I have allowed as general damages:

(a) the sum of RM75,000 for the brachial plexus injury suffered by Gurisha:

The award of general damages for the brachial plexus injury to Gurisha's left shoulder is based on the decision of the High Court in *Natahlie Nordberg v Quah Thong Sai & Anor* [2014] MLJU 1736; [2017] 10 CLJ 209; [2015] AMEJ 339; [2015] AMEJ 339; which referred to the *Compendium of Personal Injury Awards* (Revised as at 11 Oct 2013). The High Court's decision in *Natahlie Nordberg* was upheld by the Court of Appeal in *Elizabeth Chin Yew Kim & Anor v Dato' Ong Gim Huat (sued as public officer of Hospital Lam Wah Ee) and other appeals* [2017] 1 MLJ 328; [2017] 2 CLJ 509. Pursuant to the principle of stare decisis, this court is bound by the decision of the Court of Appeal; and

(b) the sum of RM47,300 as the cost of Gurisha's future medical and therapy.

[231] The costs of Gurisha's future medical and therapy are calculated based on the estimated costs set out in Table 2 below. In calculating the costs, this court took into account the expert evidence of the plaintiff's expert, Dr Kavitha Uma Ratnalingam and D1's expert, Dr Theva Raj Pannudurai and Dr Sivananthan.

[232] One of the items that the plaintiffs had claimed for is the sum of RM30,000 for future scoliosis surgery. Since both Dr Kavitha and Dr Sivananthan had confirmed that in their expert opinion Gurisha does not need scoliosis surgery in the future, I have disallowed the claim for future scoliosis surgery.

TABLE 2

COST OF FUTURE MEDICAL AND THERAPY		
Services	Estimated costs (Frequency x RM)	RM
Medical consultation with orthopaedic consultant, pediatrician	80 x RM200	16,000
Physiotherapy	100 x RM150	15,000
Occupational therapy	80 x RM120	9,600
Cognitive assessment at age 6 years	1 x RM700	700
Counselling sessions	30 x RM200	6,000
TOTAL		47,300

[233] I have disallowed as general damages:

(a) the plaintiffs' claim for pain and suffering and loss of amenities of life as this has been taken into account in the general damages given for branchial plexus Injury of RM75,000.

(c) Aggravated damages

[234] I have disallowed the claim for aggravated damages as I do not see that the facts of the case warrant a claim for aggravated damages.

(d) Interest

[235] I have awarded the plaintiffs pre-judgment and post-judgment interest as detailed in Table 3 below.

TABLE 3

INTERESTS
(1) Interest on special damages fixed at 4%pa from 14 May 2014 (date of incident).
(2) Interest on general damages at the rate of 8%pa from 10 December 2015 (date of service of writ).

(3) Interest on judgment sum, including costs, from date of judgment fixed at the rate of 5%pa until full settlement.
(4) Interest on cost, will run from 4 November 2019 (the date of the court's decision on costs).

11. COSTS

(a) Background information

[236] On 4 October 2019, this court delivered its decision that it allowed the plaintiffs' claim in clinical negligence against D1 but dismissed their claim against D2. Learned counsel for the plaintiffs asked for the issue of costs to be dealt with after the conclusion of proceedings as allowed under O 56 r 7(1) and (2) of the ROC. Counsel also informed this court that the plaintiffs are seeking a Sanderson order that D1 pay for D2's costs instead of the plaintiffs paying the costs.

[237] The plaintiffs' application for the issue of costs to be dealt with the conclusion of proceedings was allowed by this court.

[238] On 4 October 2019, the plaintiffs filed a bill of costs (Form 117) seeking: (a) the sum of RM200,000 as their getting-up fee in respect of the proceedings on liability and quantum; and (b) the sum of RM56,262.47 as out of pocket expenses. On 7 October 2019, D2 served a bill of costs (Form 117) seeking the sum of RM85,000 as their getting up fee and the sum of RM7,017.67 as out of pocket expenses.

[239] After a hearing on costs before this court on 29 October 2019, D2 reviewed their costs on transcription services and the amount that they had to pay for the services. After reviewing their costs, D2 submitted an amended bill of costs dated 30 October 2019, whereby the amount claimed as out of office expenses was increased to RM8,926.67. The plaintiffs also submitted an amended bill of costs dated 31 October 2019, where their out of pocket expenses was reduced to RM47,545.07.

(b) Sanderson order

[240] The general rule is that 'costs follow the event' except when it appears to the Court that in the circumstances of the case, some other order should be made. O 59 r 3(2) of the ROC states:

> 3 When costs to follow the event (O 59 r 3)
>
> (2) If the Court in the exercise of its discretion sees fit to make any order as to the costs of or incidental to any proceedings, the Court shall, subject to this Order,

order the costs to follow the event, except when it appears to the Court that in the circumstances of the case some other order should be made as to the whole or any part of the costs.

[241] The plaintiffs seek a Sanderson order where the unsuccessful defendant (D1) pays for the costs of the successful defendant (D2) instead of the plaintiffs paying for D2's costs. The order was named after the decision of the English Court of Appeal in *Sanderson v Blyth Theatre Company* [1903] 2 KB 533. In that case, the English Court of Appeal held that where relief is claimed against more than one defendant, the court has the jurisdiction to order the unsuccessful defendant to pay the successful defendant. However, Romer LJ in his judgment cautioned that:

> ... in exercising the jurisdiction, a judge should have regard to the circumstances of the case, and be satisfied that it is just that the unsuccessful defendant should, either directly or indirectly, have to pay the costs of the successful defendant.

[242] The Malaysian Court of Appeal in *Takong Tabari v Government of Sarawak & Ors and another appeal* [1998] 4 MLJ 512, confirmed that a trial judge has the jurisdiction make orders of costs in the nature of a Bullock order (after the order made in *Bullock v The London General Omnibus Company and others* [1907] 1 KB 264) or a Sanderson order, provided the circumstances warrant the making of such an order. Siti Norma Yaacob JCA (as she then was) in delivering the judgment of the Court of Appeal held that what constitutes a proper case for a Sanderson order, where the unsuccessful defendant is ordered to pay the costs of the successful defendant, depends on the facts of the case. Her Ladyship held that the court needs to ask itself whether it was reasonable and proper for the plaintiff to have joined the defendants in the same action in making the orders of costs.

[243] The plaintiffs submit that it was reasonable for them to have named D2 as a defendant. Learned counsel for the plaintiffs relies on the case of *Besterman v British Motor Cab Company, Limited* [1914] 3 KB 181, which involved a motor accident between a cab owned by the British Motor Cab Company and a bus owned by the London General Omnibus Company. The plaintiff was injured as a result of the motor accident and sued both companies. In that case, the Court of Appeal held that it was proper for the injured plaintiff to have named both companies as defendants because she did not have full information as whether it was the fault of the cab or the bus that caused the collision. As summed up by Vaughan Williams LJ in his judgment:

> There had been a collision, and it took place under such circumstances that the injured person would, naturally, not have full information as to whose fault it was, but it took place under such circumstances that it might have well been the fault of one or other or of both of these people.

[244] Vaughan Williams LJ went on to say:

> *The proper way is — do not join any defendant unreasonably; if the facts are such that it is reasonable to join them both and reasonable to be in a state of uncertainty as to which of the two is the really guilty one*, then it is part of the reasonable costs of the action that the costs of the action which you have launched against one of those defendants, and who has succeeded in defending himself, should be borne by the man who is to blame. *There is no rule in the matter; each case must turn upon its own circumstances, and if it is said to me*. (Emphasis added.)

[245] In the *Besterman* case, the plaintiff who was the victim of the road collision between the cab and the bus did not know who was at fault for the collision that resulted in her injury. Hence, why she had to name both companies as defendants. Whereas in the *Sanderson* case, the architect William Hope was added as a defendant to the suit against Blythe Theatre Company for work done and goods delivered, after the company denied that they or their agent had requested the plaintiff to supply materials or do work as alleged in the statement of claim. The plaintiff, Sanderson, amended the statement of claim by claiming in the alternative against William Hope the same sum as that he claimed against the company, and in further alternative claiming the same sum against William Hope by way of damages for breach of warranty of authority to order the work and materials. After William Hope was added as a defendant, the company put in an amended defence, alleging that William Hope had no authority to employ the plaintiff. William Hope, by his defence, denied that he was the agent of the company, and set up other defences identical with those set up by the company.

[246] What is clear from *Besterman* and *Sanderson*, is that the cases were an either-or scenario — it is either one defendant or the other that is liable for the negligence. In *Besterman*, it was either the cab or the bus that was liable for the accident that caused the injury to Mrs Besterman. In *Sanderson*, it was either the company or the architect William Hope who had requested Sanderson to supply the materials or do the work.

[247] Whereas in this instant case, the particulars of negligence and breach of contract pleaded by the plaintiffs in their statement of claim against D1 and against D2 are vastly different. The particulars of negligence against D1 relates to her conduct as a consultant obstetrician and gynaecologist. Whereas the particulars of negligence against D2 relate to system failures.

[248] In *McDermott v InHealth Ltd* [2018] EWHC 1835 (QB), the High Court held that it was appropriate to grant a Sanderson order because the three defendants in that case were blaming one another. All three defendants in that case denied that the scan of the claimant's brain had been sent to them but claimed that it was sent to other in an attempt to avoid liability for not spotting

A the aneurysm in the claimant's brain. Lavender J in his judgment held:

> The Claimant was not responsible for the complexities of the situation which he faced. The Claimant had not been advised of his aneurysm, there were three potential defendants and no defendant was admitting liability, nor was there to be any admission of liability for over two years after the Particulars of Claim were served.

B

Lavender J held that in the circumstances the claimant acted reasonably in suing all three defendants. Also, that in such circumstances it would not be unjust to grant an order the second defendant to bear the costs which were reasonably incurred in consequence of the second defendant's negligence.

C

[249] Whereas, in this instant case, Mdm Baljeet is left in no doubt as to who the attending the consultant obstetrician and gynecologist is, who saw her at each and every antenatal visit, who advised her (or as in this case did not advise her) of the available delivery options, who managed the labour and who delivered her baby.

D

[250] Learned counsel for the plaintiffs submit that it was reasonable for the plaintiffs to add D2 as a defendant in this instant case because: (a) they acted on Dr Lum's expert evidence; (b) D1 had tried to shift her liability on D2 by way of her claim for contribution or indemnity against D2; (c) it was reasonably foreseeable that D2 would be named as a defendant in action in clinical negligence against D1; (d) the Federal Court in *Dr Kok Choong Seng* had recognised that the law on hospital's liability 'is on the move'; and (e) the act of naming D2 as defendant saved time and costs.

E

F

[251] The facts in this case show that D1 did not try to shift the blame on D2 for the injuries suffered by Gurisha and Mdm Baljeet. She agreed that the blame for delivering the wrong set of forceps with two left blades is with Pantai Hospital KL. But she never claimed that Pantai Hospital in delivering the initial wrong set of forceps had contributed to the injuries suffered by the plaintiffs. Also, D1 never echoed Dr Milton Lum's criticism of D2 for what is in his opinion an inadequate number of nurses attending to the delivery and its failure to comply with standard operating procedures. Unlike the defendants in *McDermott v Inhealth Ltd*, D1 did not contribute to the plaintiffs' decision in suing D2.

G

H

[252] Additionally, I am unable to agree with the plaintiffs' contention that D1's notice of indemnity and contribution against D2 influenced the plaintiffs' decision to sue D2. The plaintiffs had filed their writ and statement of claim against D1 and D2 on 7 December 2015. D1 filed her defence on 22 January 2016 and D2 filed its defence on 7 January 2016. D1 only filed her notice of indemnity and contribution against D2 on 23 September 2016 after D2 had

I

filed a notice of indemnity and contribution against her. I am puzzled how D1's notice of indemnity and contribution against D2 filed nearly a year after the plaintiffs had filed their writ and statement against both D1 and D2, can be said to have influenced the plaintiffs' decision to sue D2.

[253] Learned counsel for the plaintiffs submits that it was reasonably foreseeable that D2 would be named as a defendant because D1 (in cl 3(s) of the consultant agreement) had covenanted to indemnify D2 and/or Pantai Hospital KL against any claims or actions brought against D1 or D2 and/or Pantai Hospital KL in respect of D1's acts or omissions or that of her employees/ agents.

[254] With respect to Mr MS Dhillon, I am unable to accept his submission. Clause 3(s) of the consultant agreement is an obligation for D1 to indemnify D2. It only comes into operation if D2 is found liable for a patient's injury and must compensate the patient because of D1's negligence. Furthermore, the plaintiffs are strangers to the consultant agreement between D1 and D2. It is trite law that a stranger to a contract may not rely on the terms of a contract which he is not party to: see *Scruttons v Midland Silicones Ltd* [1962] 1 All ER 1.

[255] Another ground submitted by Mr Dhillon as to why it was reasonable for the plaintiffs to name D2 as a defendant and for this court to grant a Sanderson order for D1 to pay for D2's cost, is the Federal Court's recognition in *Dr Kok Choong Seng* of Lord Sumption's dicta in *Woodland* that 'the law of vicarious liability is on the move'.

[256] I agree with Lady Hale's dicta in *Woodland* — where she had repeated what was said by many judges before her — that a court cannot treat judicial statements and words used by judges in explaining why they are deciding the way they do as if they are words of statute. Lady Hale said as follows:

> 28 The common law is a dynamic instrument. It develops and adapts to meet new situations as they arise. Therein lies its strength. *But therein also lies a danger, the danger of unbridled and unprincipled growth to match what the court perceives to be the merits of the particular case*. So it must proceed with caution, incrementally by analogy with existing categories, and consistently with some underlying principle (see *Caparo Industries plc v Dickman* [1990] 2 AC 605*). But the words used by judges in explaining why they are deciding as they do are not be treated as if they were the words of statute, setting the rules in stone and precluding further principled development should new situations arise.* These things have been said many times before by wiser judges than me, but are worth repeating in this case, where we are accepting an invitation to develop the law beyond the point which it has currently reached in this jurisdiction. It is because we are doing that, and thus disagreeing with the conclusions reached in the courts below, that I am adding a few thoughts to the judgment of Lord Sumption, with which of course I agree.

A ...

38 I also agree that the principle will apply in the circumstances set out by Lord Sumption at paragraph 23, *subject of course to the usual provisos that such judicial statements are not to be treated as if they were statutes and can never be set in stone.* (Emphasis added.)

B

[257] Accordingly, just because the Federal Court in *Dr Kok Choong Seng* referred to Lord Sumption's statement that 'the law of vicarious liability is on the move' does not mean that in all cases of medical negligence, it is reasonable C for the plaintiff to name the hospital and/or the owner of the hospital as a defendant regardless of the facts and circumstances of the case. To do so would be to ignore the Federal Court's answers to the second and fourth questions posed in *Dr Kok Choong Seng*, which are as follows:

D [70] Thus, we would answer the second question as follows: given the fact-sensitive nature of the *Woodland* test, *whether private hospitals are in breach of a non-delegable duty to their patients by reason of the negligence of doctors practising there cannot be predetermined by a general pronouncement, but assessed based on the facts and circumstances of each case.* We are satisfied that the defining features of non-delegable duties identified in *Woodland* are not present in the instant case, and accordingly we E find the hospital not liable for breach of a non-delegable duty to the plaintiff.

...

[97] The test for vicarious liability in *Various Claimants* requires the court to determine the nature of the relationship between the hospital and the medical F practitioner, and the connection between that relationship and the wrongful act by the practitioner. *The determination is a question of fact, based on a consideration of multiple factors and calls for an evaluative judgment. The terms regulating the general relationship between a hospital and a practitioner, and the particular terms applicable in the circumstances of the alleged negligence, may vary from case to case. As such, the* G *vicarious liability of the private hospitals for the torts of medical practitioners cannot be determined with a broad brush in a factual vacuum.* (Emphasis added.)

[258] Moreover, in *Dr Kok Choong Seng*, the Federal Court held that as the boundaries of vicarious liability had not been expanded to include those who H are clearly independent contractors, it is necessary to look at the agreement between the doctor and the hospital to determine the 'vestigial degree of control' and whether the operation in question was undertaken on behalf of the hospital or was it attributable to the doctor's own 'recognisably independent business'.

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[259] Therefore, for these reasons, I do not find that it is just and fair in the circumstances to a grant a Sanderson order. Accordingly, the plaintiffs' application that the unsuccessful defendant (D1) pays for the successful defendant's (D2) costs is dismissed.

(c) Order as to costs

[260] The plaintiffs' costs allowed by this court are made up of the following:

ITEM	AMOUNT (RM)	
1. Getting-up for liability proceedings		100,000
2. Getting-up for quantum proceedings		30,000
3. Out-of-pocket expenses		42,215.07
a. Filing fee	1,168	
b. Transport	500	
c. Experts fees and expenses		
i. Dr Milton Lum	17,500	
ii. Dr Kavitha Uma Ratnalingam	13,500	
d. Printing, binding and photocopying	3,305.05	
e. Courier fees	36.35	
f. Purchase of CD	30	
g. Cost of transcribing notes of proceedings	3,675.67	
h. Medical report — Dr Gunasegaran	500	
i. Witness allowance	2,000	
TOTAL		172,215.07

[261] It is hereby ordered that D1 pays the sum of RM172,215.07 as costs to the plaintiffs.

[262] D2's costs allowed by this court are made up of the following:

ITEM	AMOUNT (RM)	
1. Getting-up for liability and quantum proceedings		50,000
2. Out-of-pocket expenses		6,565.67
a. Filing fee	580	
b. Transport	500	
c. Printing and photocopying	1,300	
d. Fax & telephone	269	
e. Courier fees	8	
f. Commissioner of Oaths fees	20	
g. Cost of transcribing notes of proceedings	3,675.67	
h. Translation fees	213	
TOTAL		56,565.67

[263] It is hereby ordered that the plaintiffs pay the sum of RM56,565.67 as costs to D2.

Plaintiffs' claim against the first defendant allowed with costs of RM172,215.07; plaintiffs' claim against the second defendant dismissedwith costs of RM56,565.67

Reported by Kohila Nesan